STATE TITLE V BLOCK GRANT NARRATIVE
STATE: IN
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

Assurances and Certifications are kept on file at the Indiana State Department of Health both in the Finance Department and in the office of the MCSHC Grants Coordinator with the hard copy of the grant application. They are available upon request.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

The State Title V program solicited public comments for this application by placing an Executive Summary of the FY 2005 application on the MCSHC web page. The web page provides the public an opportunity to review the Executive Summary and provide comments. After MCHB review, access to the entire application is also provided on the website. Copies of the Executive Summary were made available upon request and were also accessible in government document sections of thirteen public libraries across the state. A legal notice was placed in all major newspapers in the state alerting readers to the placement of the documents.

ISDH will post the 2006 executive summary on the MCSHC web page and distribute the summary and the application electronically to the membership of the various MCSHC advisory committees and to all public libraries in the State. All public comments are recorded along with ISDH MCSHC response and all comments and responses are used during the preparation of the application for the following year. ISDH will announce the web location of the executive summary by legal notices placed in all major newspapers in the state.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

Indiana elected a new Governor, Mitchell E. Daniels, Jr. in 2004.
Governor Daniels appointed Dr. Judith Monroe as the State Health Commissioner and Medical Director for Medicaid, the first woman appointed to head the health department and the first person to hold both positions simultaneously. Dr. Monroe's background is Family Practice Residency Training and Primary Care.

PRINCIPLE CHARACTERISTICS of STATE HEALTH NEEDS
Population -- 6,195,643
Statewide, Indiana's population grew by about 3 percent between 2000 and 2002, with most of the growth coming from more births than deaths and people moving to the state from other countries. Indiana grew at a slightly faster pace than neighboring states from 2000 to 2003, but well below the fastest growing states such as Georgia, Nevada and Idaho, all above 7%.

Hundreds moved out of Madison County between 2000 and 2004. Between 2001 and 2004, manufacturing jobs in Madison County dropped from 9,781 to 7,180. Henry, Grant, Wayne, Randolph and Rush counties in east-central Indiana also experienced population declines after the loss of manufacturing jobs. Widespread population loss also occurred in Newton, Vermillion, Knox and Posey counties along the Illinois border. The drops in Vermillion and Knox are attributed to deaths outnumbering births.

Whites make up 89% of Indiana's population. Approximately 8.5% of the state's population is Black. Marion County (Indianapolis) and Lake County (Chicago area) have the highest concentrations of African Americans, representing 24%-25% of each county's population. Other counties with urban centers and manufacturing job concentrations also have significant numbers of African Americans, the next highest being St. Joseph, Allen and LaPorte Counties at 10%-12% of their population.

The Ku Klux Klan has resurfaced across Lake, Porter and LaPorte Counties and was implicated in the burning of a house being built for a black family in Lake Station. The City of Gary has started community meetings to address recent racism.

At 1.2% of Indiana's population, Asians are the fastest growing minority with the highest concentration at 4.5% in Tippecanoe County, home to Purdue University. Monroe and Hamilton Counties also have more than 2% Asian representation. Numerically, the greatest concentration of Asians is in Marion County (12,325 = 1.4%).

The largest increase among Indiana's population has been among the Hispanic ethnic group. Hispanics make up 3.5% of the state's population with the greatest concentration in Lake County, representing 12.2% of the population. The next closest county is Elkhart at 8.9%. Other counties that show the largest growth in Hispanic population include Marion, Allen, Tippecanoe and Porter. The influx of Spanish speaking people has caused hospitals, clinics, public safety and educational institutions to train personnel in Spanish language and Hispanic culture.

The second fastest growing minority population in Indiana is the Amish, with populations expected to double in 20 years. Concentrated in the northeast corner of the state, Indiana's Amish face unique challenges. The Elkhart-LaGrange settlement is the 3rd largest in the US and while the US Census does not track Amish populations, local estimates show about 3,300 school age (1st-8th grade) Amish children in Elkhart-LaGrange. According to estimates developed by Indiana University of Fort Wayne through the Amish Youth Vision Project, the total Amish population could be as high as 45,000 in this part of the state. An unusually high percentage of this population works in local factories -- more than 40% of Amish men.

During late teen years through their early twenties, Amish youth are not required to join the church and are not bound by its teachings. This tradition, known as Rumspringa, grows from the belief that

Amish must join the church of their own free will. However, as documented in "The Devil's Playground," a video documentary prepared for the Public Broadcasting System, this population, particularly young Amish men are extremely vulnerable to drug use and other illegal and occasionally violent behavior -- particularly for factory workers who, unlike the Amish working in farming and small business, have free time, low cost of living and significant disposable income. Population increase and limited land availability put additional pressures on the Amish as their larger communities grow to several times the traditional settlement size.

American Indians are one of the smallest minority groups in Indiana, making up 0.6% of the state's population, trailed only by Pacific Islanders at 0.1%. This population is scattered across the state. Only three counties, Marion, Lake and Allen have total American Indian populations of more than 1,000. Most counties have fewer than 100.

While Indiana's labor force grew, employment levels steadily decreased from 1999 to 2003, causing a jump in the unemployment rate from 3% to 5.1%. This current unemployment rate is below average for the Midwest region. Kentucky has the lowest regional unemployment rate at 4.5%; Michigan has the highest at 6%.

Between 1999 and 2002, Indiana's poverty rate increased from 8.7% to 9.6% - still below the national average of 12.1%. The U.S. Census estimated in 2002 that 11.9% of Indiana's children live in poverty, with a higher rate of 14.5% for children under age 5. In Indianapolis, approximately 15,000 people are homeless in any given year, and an additional 45,000 people are in a housing crisis.

Indiana requires impoverished families to pay income tax. Currently, families begin paying state income tax when they earn 76% of the federal poverty level. This tax threshold could be lowered to 36% if the state Earned Income Tax Credit is not upheld for 2005. Specifics can be found at the Center on Budget and Policy Priorities - http://www.cbpp.org/4-12-05sfp-in.pdf

The Robert Wood Johnson Foundation used data collected by the Centers for Disease Control and Prevention to estimate that in 2003, there were more than 600,000 (16.3%) uninsured adults ages 18 to 64 in Indiana. The U.S. Census estimates the national uninsured rate at 13.9%. In 2003, 161,815 (9.6%) children in Indiana under age 19 were uninsured.

Indiana ranks 46th for the percent age 25+ with BS, BA or graduate degrees at 21.1%. The state's economy still is based heavily on manufacturing. College graduates tend to leave the state for better pay. Indiana University is proposing a 4.9% tuition increase for undergraduate courses. The increase would cost undergraduates as much as $335 more in tuition and mandatory fees per semester. Purdue University is considering a 6% hike that would cost undergrads $366 more.

In 2004, State Police alone arrested more than 1,200 people as a result of methamphetamine lab busts -- which affected the lives of at least 219 children, most of them related to the arrested adults and subsequently thrust into the state's child protection system. Last year, state officials estimated, more than 30 percent of neglect and abuse cases they handled were in some way connected to methamphetamine abuse or manufacture. New legislation requires cold medications containing components used in methamphetamine manufacture to be controlled by pharmacists from behind the counter.

The Environmental Integrity Project named 12 Indiana coal-burning power plants, including one on the Southside of Indianapolis, among the 50 "dirtiest" in the country for producing health-damaging pollutants. The report underscores the potential health threat from power company smokestacks throughout Indiana. With one exception, the Indiana companies did not challenge the group's findings. The report, "Dirty Kilowatts: America's Most Polluting Power Plants," compiled data from the U.S. Environmental Protection Agency and the Department of Energy's Energy Information Administration for sulfur dioxide, nitrogen oxides, mercury and carbon dioxide. The mercury data were from 2002, and the rest of the information came from 2004. See http://www.environmentalintegrity.org/pub315.cfm

According to the Indianapolis Star, April 15, 2005, Marion County's child welfare program faces a $20 million deficit and will likely have to borrow money this year to feed and clothe more than 3,000 children. An increase in the number of children needing care has driven costs up. New children sent into the system by the juvenile court in 2004 had increased to more than 2,000, up from a figure of 540 in 1996. The Office of Family and Children is largely paid for by county taxes but is managed by the state, leaving county elected officials holding the purse strings with no oversight on spending and little incentive to increase funding. Similar structural problems statewide played a role in the development of a separate Department of Child Services at the state level distinct from the rest of state social services.

Planned Parenthood of Indiana sued Attorney General Steve Carter to stop his office from seizing the medical records of 73 low-income Medicaid patients who have sought reproductive services. None of the records involves abortions. The Attorney General's Medicaid Fraud Control Unit was investigating an incident report or complaint alleging failure to report statutory rape. The eight records already turned over are of 12- and 13-year-old patients. In Indiana, anyone under age 14 who is sexually active is considered to be a victim of rape. Planned Parenthood maintains its personnel follow the law and report those patients to child protective services for further review. The Indiana Civil Liberties Union filed the lawsuit on behalf of Planned Parenthood. The record seizure has been postponed by court injunction.

Signed by Governor Daniels, new 2005 State Laws:
*Create a new cabinet level Department of Child Services to provide child welfare and protective services. This department takes over these duties from the Family and Social Services Administration (FSSA)
*Require all counties of Indiana to observe Daylight Savings Time beginning 2006. Since 1971, most of Indiana has not observed DST while the counties nearest Chicago synchronized with Chicago
*Require FSSA Department of Mental Health, Indiana Department of Child Services and Indiana Department of Education to develop a plan for children's emotional and developmental health
*Require FSSA Office of Medicaid Policy and Planning to seek a family planning waiver for Medicaid
*Create a state Department of Homeland Security to take over duties from several state agencies that will be abolished or re-assigned
*Provide health coverage for the surviving spouse and dependent children of active Indiana State Police officers killed in the line of duty
*Increase the penalty for voyeurism from a misdemeanor to a felony if the offender has a previous conviction for voyeurism
*Start a "Code Adam" program to help find missing children in certain state buildings. The system would notify state employees about a missing child in the building, and employees could then stop normal work to help search for the child and monitor exits
*Make it a misdemeanor for someone to intentionally provide dental hygienist services without a license
*Require most voters to show State issued or military ID to cast a valid vote (Indiana's ACLU has filed suit to contest this law on behalf of homeless and low-income residents)
*Create the Office of Inspector General, reporting to the Governor, to investigate fraud and abuse in state government and tighten State ethics rules
*Restrict the sale of cold medicines that contain chemicals that can be used to create methamphetamines
*Raise speed limits on most state highways to 60mph and Interstate highways to 70mph
*Require child care homes that receive a voucher payment and licensed child care homes to receive training concerning safe sleeping practices for children and require the Division of Family and Children to provide or approve training concerning safe sleeping practices for children
*Require ISDH to adopt rules for the case management of children with lead poisoning and allow ISDH to coordinate lead poisoning outreach programs with social service organizations and require OMPP to develop measures to evaluate Medicaid managed care organizations in screening children for lead poisoning, a system to maintain the results and a performance incentive program
*Require ISDH to develop storm safety guidelines to schools and make them available to child care

centers, day care centers and public parks and require Department of Education to distribute the guidelines to all public and non-public schools in Indiana.

Governor Daniels formed a Hoosier Health Care Cabinet, a group of state employees with backgrounds in health care delivery and financing. Cabinet members include Family and Social Services Administration (FSSA) Secretary Mitch Roob, State Health Deputy Commissioner Sue Uhl, FSSA CFO Dick Rhoad, FSSA Director of Health Policy for Medicaid Jeanne LaBrecque and FSSA Chief of Staff Anne Murphy. The direction for this group is not yet available.

Gov. Daniels announced a new statewide program to help Hoosiers find and apply for programs providing free or lower cost prescription drugs. The program will expand on a privately run program in southern Indiana. The Evansville program allows people to access low-cost prescription drug programs by inputting basic information into a computer web site. The system searches for the best discount program and provides the application. Concerned that only one in 10 people who are eligible for such programs take advantage of them, the governor hopes "RxforIndiana" will bolster those numbers. "RxforIndiana" will offer information on more than 2,400 drugs and more than 300 discount programs, including those run by pharmaceutical companies and the state. The site, www.rxforindiana.org, includes a Spanish-language version and a toll-free number, (877) 793-0765, which has Spanish-speaking operators to help guide the individual through the application process.

ISDH CURRENT PRIORITIES and INITIATIVES
Indiana State Department of Health (ISDH) is charged with central planning and regulatory development and administration for all health care delivery in Indiana and with improving the overall health of the population through education, advocacy and program support. Indiana's 94 local health departments operate independently from ISDH as arms of local or county government. Many local health departments receive grants from ISDH Maternal and Children's Special Health Care (MCSHC), the division charged with carrying out the goals of Title V of the Social Security Act.

Indiana has a mix of for-profit and not-for-profit hospitals and a broad array of local clinics, many of which are also ISDH MCSHC grantees. Additionally, MCSHC contracts with a number of consulting groups, media services organizations and universities to provide planning, educational and public information programs to advance maternal and child health in the state.

STATE HEALTH PERFORMANCE PLAN
Indiana State Department of Health (ISDH) issued the 2005 State Health Performance Plan (SHPP) that set priorities in two areas: Health Status and Health Systems. Health Status Goals: Chronic Disease (heart disease, cancer, diabetes, asthma, hypertension), Infant mortality and prematurity, Minority health disparities, and Obesity. Health Systems Goals: Access to primary care (particularly for underserved populations), Health care quality (Regulation, Promoting evidenced-based medicine and best practices) and Public health infrastructure (Staffing {number, skills/training, age}, Budgets, Communication and Information Technology).

The following sections from the SHPP outline priorities for which MCSHC is partly or primarily responsible.

The SHPP identifies baseline chronic disease levels in Indiana and sets goals for 2010 in relation to the Healthy People 2010 goals. These goals include both total disease indicators and weighted indicators for Black and Hispanic populations. SHPP notes a 2002 baseline of 1.3 asthma-related deaths per 100,000 among children age 0-14 and a goal of 1/100,000 by 2010. For Black children, the 2000 baseline is 6.3 deaths per 100,000 with a 2010 goal of 3.8/100,000. ISDH Priority Goal: Reduce asthma morbidity and mortality rates in Indiana.

SHPP shows a 2002 baseline of 7.6 infant deaths in 1,000 (6.5 white, 15.6 black), 9.4% prematurity (9% white, 12.5% black) and 7.6% low birth weight (6.9% white, 12.9% black). ISDH Priority Goal: Decrease Indiana's infant mortality and prematurity rates.

Obesity in Indiana is epidemic. SHPP notes 61.3% of adults are overweight and 26% obese (2003). Among high school students, those rates are 25.7% and 14.2%. ISDH Priority Goal: Decrease the percentage of overweight and obese persons in Indiana.

Agency Priority Goals are to: Increase the number of minorities entering the field of public health; Develop a more culturally competent workforce; Enhance access to primary care; Promote and improve the quality of health care provided by Indiana health care providers; and, Improve Indiana's public health care infrastructure.

TITLE V PRIORITY SELECTION
The MCSHC statewide needs assessment is the first step in determining priorities, identifying emerging issues and planning the development and delivery of Title V services.

ISDH MCSHC contracted with an epidemiologist to pull together information from 10 regional epidemiologists in the State's Public Health Preparedness program, along with other statistical information and data generated by other consultant contractors to create the 2006-2010 MCSHC Needs Assessment. Below is an overview of those findings not previously detailed in the SHPP above.

Rates of overweight and obesity increased in Indiana from 1999 to 2002, mirroring national trends. Currently, more than 60% of Indiana's population is overweight, with more than 25% obese. These rates are slightly higher than national averages.

Only 42.8% of Indiana women were normal weight before pregnancy in 2001. According to the CDC Pregnancy Nutrition Surveillance System of pregnant women participating in WIC, 13.4% were overweight, 29.2% were very overweight, 9.7% were underweight and 4.9% were very underweight.

Pregnancy rates among Indiana women age 20 and less decreased from 3.2% in 1999 to 2.6% in 2002. Black teenagers are 2.5 times more likely to become pregnant than white teenagers.

Between 1999 and 2001, the number of induced pregnancy terminations in Indiana decreased by 1.94% to a total number of 11,281 pregnancy terminations in 2001.

Indiana's 2002 birth rate was 1.38%, below the national average of 1.39%.

In 2002, there were 40 infant deaths due to SIDS in Indiana resulting in a SIDS age specific death rate of 47 per 100,000 live births. The Healthy People 2010 goal is to reduce the SIDS mortality rate to 30 per 100,000 live births. In whites SIDS is the third leading cause of death with age specific death rate of 45.3 per 100,000 live births (n=33) where as in blacks SIDS deaths ranked 5th (n=14) after short gestation/low birth weight disorders, congenital defects, accidents, and maternal pregnancy complications.

At 19.1% in 2002, Indiana has the 6th highest maternal smoking rate among 49 reporting States. This rate is higher among whites than blacks. While Indiana has seen a steady decrease in this rate, it is unlikely the state will reach the HP2010 goal of no more than 1%.

However, results from the 2004 Indiana Youth Tobacco Survey show that the percentage of children who smoked in grades 6 through 8 dropped to 7.8% from 9.8% in 2000. In grades 9 through 12, the percentage of smokers dropped to 21% from 32% in 2000. Nationally, 22.3% of high school students and 8.1% of middle school students said they had smoked cigarettes last year, according to CDC.

Indiana's infant mortality rate of 0.76% (7.6/1000 live births) in 2002 was higher than the national average of 7/1000. Of the total 649 infant deaths in Indiana in 2002, 68% occurred during the first 28 days of life. The remaining 32% were between 28 and 365 days. White infant mortality was 6.5 while black infant mortality was 15.6 (2.4 times the rate for white infants.)

Racial and income-based disparities exist in nearly all health statistics with low-income women and women with less than high school diploma or GED experiencing higher rates of asthma, obesity, diabetes and heart disease and experiencing these problems at earlier ages. Despite concerted efforts, the black infant mortality rate remained about 2.5 times higher than the white in Indiana. The vast majority - 89% of Indiana's population is white. However, minority populations are growing faster than the white population with the highest growth rate (62%) among Asians.

According to the 2003 US National Immunization Survey, Indiana has remained above the national average for percentage of children vaccinated for most individual antigens and all vaccination series.

In 2002, 15.7% of Indiana households had at least one child with asthma. According to the Office of Medicaid Policy and Planning (OMPP), of 23,161 children age 0-17 enrolled in Medicaid in 2003, 10% had an emergency room visit with principal diagnosis of asthma and 4% were hospitalized for asthma. Asthma is the most common diagnosis among children enrolled in CSHCS.

Between 1999 and 2003, Allen, Clinton, Elkhart, Lake, Marion, St Joseph and Wayne Counties had the highest number of children with elevated blood lead levels. Except Elkhart, these counties have percentages of children living below poverty well above the state average of 14.4%. In 2003, the Childhood Lead Poisoning Program indicated that 2.9% of 31,413 children screened had elevated blood levels.

Indiana Attorney General Stephen Carter has provided a letter of support to all local health departments and cities applying for lead poisoning prevention and abatement grants indicating an aggressive stance to require landlords to reduce lead paint hazards and pursuing legal expenses in cases requiring court action.

Use of protective dental sealants among Indiana children increased by 13.5% from 1999-2003. Further data indicates sealants are increasing among all races. At 47.2% in 2002, Indiana was very close to the HP 2010 goal of 50% of children receiving protective dental sealants.

The leading causes in Indiana's 2002 adolescent death rate of 83.2/100,000 were unintentional injury 43.9%, homicide 14.5% and suicide, 13%. Homicide was the leading cause of death for black adolescents in Indiana, accounting for more of the 147.65/100,000 death rate than all other causes combined.

From 1999 - 2003, reported cases of child abuse fluctuate between 3,620 and 4,415. Neglect cases rose to 15,634 in 2000 and tapered to 12,308 in 2003. However, a number of high profile cases during the election of 2004 have placed attention on this issue. Governor Daniels campaigned with a promise to separate child protective services from FSSA.

Self-reported monthly alcohol use among high school seniors has dropped from 51.7% to 46.1% from 1999-2003, mirroring national averages. Marijuana and psychedelic consumption has also dropped. Cocaine use remained at 2.5% among Indiana adolescents in 2003, above the national average. Inhalant use also increased among younger adolescents.

DEVELOPMENT OF PRIORITIES
ISDH MCSHC determines priorities based on the following considerations: health and capacity data; priority survey data; state health plan; MCH objectives; and what other organizations are doing statewide. Priorities must meet the following criteria: ISDH must be able to address the problem; solutions must be feasible; resources must be available; and the problem must fit with purposes of Title V, Healthy People 2010, and the Governor's priorities. ISDH MCSHC addresses priorities through commitment of funding, staff time and working to focus the efforts of ISDH and other agencies on those priorities. MCSHC continuously evaluates programs and monitors emerging issues through staff effort and contracts with consultants to conduct needs assessment, project evaluation, public hearings, focus groups, surveys and analysis.

B. AGENCY CAPACITY

In the State of Indiana, the Title V program is administered through the Maternal & Children's Special Health Care Services division (MCSHC) of the Indiana State Department of Health (ISDH) Community & Family Health Services Commission. MCSHC manages a number of funds from federal and state sources including Title V for an estimated total allocation of $35,832,070 for FY 2005. Additionally, most MCSHC grantees leverage local resources to provide a required 30% match to grant funds. MCSHC extends the capacity by outsourcing services to local entities.

MCSHC provides funding for projects in all levels of the MCH Pyramid. MCSHC staff is directly involved in infrastructure building within ISDH, among other state agencies, and among non-state agencies. Through the Title V Block Grant Federal/State Partnership, MCSHC funds agencies to provide direct medical services for women of childbearing age, pregnant women, infants, and children and acts as payer of last resort for primary and specialty care for children with special health care needs (CSHCN). These grantees/contractors also provide enabling services (such as care coordination) to prenatal clients and to families of CSHCN. MCSHC also creates and implements population-based education on topics like adolescent pregnancy prevention. See Narrative Part C for a detailed list.

MCSHC staff interface with state physician and dental organizations, Office of Medicaid Policy and Planning (OMPP) and other managed care insurers (especially those working with low-income populations), laboratories that run the newborn screens and meconium screens, not-for-profit groups that are working toward the same improved health outcomes as ISDH MCSHC and other state agencies to coordinate and assure that quality health care is available. MCSHC also monitors statistics for Indiana's Health Status Indicators (HSI) and health outcomes and shares this information with the public.

ISDH is the statutory authority for Maternal and Child Health (Title V) programs, receiving state funds to match Title V funding. By statute, ISDH also operates through MCSHC the following state programs: Children's Special Health Care Services (CSHCS), Newborn Screening and Follow-up, which includes Sickle Cell Education, Screening for Drug Afflicted Babies, Adolescent Pregnancy Prevention, follow-up and education, Universal Newborn Hearing Screening, and Indiana Birth Defects and Problems Registry.

MCSHC provides information, referral and assistance to Indiana citizens statewide through the Indiana Family Helpline (IFHL). IFHL helps families and individuals access social and health services for mothers, children and families through telephone and e-mail contact. IFHL has bilingual employees, uses the ATT Language Line, and a TTY line to better serve the hearing impaired. IFHL is obtaining Alliance of Information & Referral Services accreditation to qualify to become a 211 Information and Referral (I&R) call center for some Indiana counties.

Genomics / Newborn Screening Program goals include increasing public and professional awareness of genetics, assuring access to services, enhancing genetic data collection statewide and improving the quality of the birth defects surveillance system. MCSHC funded projects offer genetic testing, evaluation and counseling, and prenatal diagnosis through support of five regional genetics projects that sponsor clinics in thirteen sites. The Genomics Program Director offers consultation to these and nine (seven non-funded and two state funded) additional Genetics Centers/Programs in Indiana. Genomics also facilitates the Folic Acid Initiative, sponsored by Title V and WIC, a population-based education effort and "Genetics and Your Practice", sponsored by MCSHC and March of Dimes, a professional training opportunity.

MCSHC capacity to expand data integration and ISDH program integration was enhanced with receipt of the Genetics Implementation Grant (GIG) in September 2002. Through this grant, the MCSHC Genomics program assists with newborn screening, birth defect and other chronic disease data integration as well as establishment of medical home, folic acid and genetics education for

professionals and consumers. The scope of MCSHC Genomics includes adult chronic diseases and general genetics education and bridges the perinatal and child health services. The Genomics program strives to increase the awareness and understanding of genetic conditions and ensure that all of the approximate 5,000 infants born in Indiana each year with birth defects or genetic conditions have access to genetic services.

Genomics collaborates and coordinates with regional genetic centers (both state sponsored and private providers of genetic services) as well as local agencies, individual providers, hospitals, health departments, the Indiana Perinatal Network (IPN), and the Indiana Chapter of the March of Dimes and builds public health genetics capacity within ISDH. Genomics also houses the Indiana Birth Defects and Problems Registry (IBDPR).

1. Pregnant Women, Mothers and Infants
MCSHC provides the Free Pregnancy Test program, a population-based enabling service intervention to reduce infant mortality and encourage women to access early prenatal care. The program provides agencies serving women of childbearing age free pregnancy tests to use as an outreach service for hard-to-reach clientele. The goals of the program include: (1) helping pregnant women obtain early prenatal care, Hoosier Healthwise, and WIC; (2) encouraging women to obtain a high school diploma or GED; (3) decreasing infant mortality and morbidity and the incidence of low birthweight; (4) assisting local communities and grantees to assess for service gaps for planning of future programs; and (5) assisting non-pregnant adolescent women into the health care system through Hoosier Healthwise enrollment. Through this program, MCSHC has developed an infrastructure of agencies that focus on women of childbearing women age and has created an ongoing database for assessment and evaluation of services offered and needed by sexually active, low-income women. Currently, the Free Pregnancy Test program is available in 63 counties.

MCSHC provides preventive, primary care, and enabling services for pregnant women, mothers and infants including prenatal health care services through grants to 13 agencies to promote direct prenatal medical services as well as funding 23 prenatal care coordination projects. The primary objective of these grants is to decrease infant mortality and low birthweight by providing quality, comprehensive, holistic health care to low-income pregnant women in community settings. MCSHC funded prenatal care coordination programs develop and coordinate access to community-based health care services for pregnant women and their families at risk for poor pregnancy outcomes. Prenatal care coordination grantees provide outreach and home visiting by certified professionals and paraprofessionals to Medicaid eligible women and some non-Medicaid clients. The direct medical and enabling services target pregnant women with low incomes and pregnant women who are high-risk because they reside in medically underserved areas. MCSHC staff also trains and certifies community health workers to assist prenatal care coordinators. MCSHC collects, analyzes and disseminates perinatal outcomes to communities to ensure that the planning and delivery of perinatal heath care services meet the needs of the population.

MCSHC develops and enhances capacity to promote and protect the health of all mothers, children and families through 13 family care coordination projects that provide enabling service to facilitate a seamless delivery of services for mother and children through outreach, assessment, care planning, advocacy, referral, education and counseling on health behavior risk reduction during both clinic and home visits with the family. Goals are to improve utilization of EPSDT services, immunization service, and primary care providers, and to empower families with education and support to access health, education, and social services they need.

MCSHC provides Family Planning and Women's Health Services through 11 local grantee agencies. The Indiana Family Health Council (Indiana's Title X agency) is contracted to provide clinic monitoring and standards of care for these grantees.

The Prenatal Substance Use Prevention Program (PSUPP) is funded through a grant from FSSA Division of Mental Health and Addiction (DMHA) and supplemented with Title V Federal -- State Block Grant Partnership and funds from Indiana Tobacco Prevention and Cessation (ITPC). PSUPP works

to prevent birth defects, low birthweight, premature births, and other problems associated with prenatal substance use. There are three primary objectives: (1) identify high risk, chemically dependent pregnant women, provide perinatal addiction prevention education, promote abstinence, provide referrals for treatment, and follow-up; (2) facilitate training and education for professionals and paraprofessionals who do not provide substance abuse treatment, but do work with women of childbearing age, on how to identify high risk, chemically dependent women; and (3) provide public education on the possible hazards to a fetus when alcohol, tobacco, and other drugs are used during pregnancy. Free posters, brochures, and other materials are available upon request through the Indiana Family Helpline. MCSHC supports enabling services for drug use cessation through 15 grantees. In addition, the PSUPP Director builds professional capacity through professional training. This program also interfaces with smoking cessation efforts with prenatal services and ISDH by providing public education.

MCSHC Newborn Screening facilitates newborn screening and follow-up programs including metabolic screening, sickle cell follow-up, hearing screening programs, and meconium screening to test for drug-afflicted babies. Newborn screening is performed on every infant born in Indiana. The program is funded by a $62.50 fee for each infant screened collected from each birthing facility by the central testing lab under contract with ISDH MCSHC. The contractor remits $30.00 of each fee to ISDH and retains the balance to pay for laboratory and collection services. Indiana University Medical Center Newborn Screening Laboratory (IU NBS Lab) is the laboratory designated by the Indiana State Department (ISDH) for processing specimens.

A blood test (by heel-stick) is done on all infants shortly after birth to test for 39 metabolic or genetic disorders. Follow-up is done to obtain repeat screens on all abnormal and unsatisfactory screens. If further follow-up is needed, the Newborn Screening Section requests assistance from the local Public Health Nurse. Infants that have a positive screen for one of the designated genetic disorders are referred to the Metabolic Specialist or the Endocrinologist at the Indiana University Medical Center. The ISDH NBS Section works collaboratively with IU NBS Lab, Sickle Cell Program, and the Genomics Program to ensure follow-up and treatment for all infants diagnosed with one of the designated disorders.

The MCSHC Early Hearing Detection and Intervention (EHDI) program screens all infants born in Indiana for possible hearing impairments. Those found with hearing impairments receive early intervention and follow-up services. UNHS coordinates with Indiana First Steps Early Intervention Services, hospitals, providers, and other agencies to provide statewide implementation. The goals for infants that do not pass the hearing screening are to receive audiology evaluations by three months of age and to be enrolled in an appropriate intervention program by six months of age. MCSHC EHDI collects comprehensive monthly data via Monthly Summary Reports (MSR) from each of the 108 birthing facilities throughout the state of Indiana and is developing a web-based electronic reporting system to enhance hospitals, audiologists and early intervention coordinators in ensuring timely and accurate evaluation and follow up treatment. The program educates the public, including parents and primary care physicians of the importance of early detection and intervention and works in conjunction with the Indian School for the Deaf to promote awareness and parent participation in the program.

MCSHC funds programs for Sickle Cell and Other Hemoglobinopathies. This program provides penicillin, education, care coordination, and counseling for sickle cell clients in the state. There are four regional sites for the care coordination. The Indiana Hemophilia and Thrombosis Center, Inc. (IHTC) also provides sickle cell education to families statewide. This program provides education and consultation to primary and hospital emergency room providers about current therapy for sickle cell disease complications and educational materials to health care providers and patients' families. MCSHC supports the Parents Empowering Parents (PEP) program to assist families living with children with Sickle Cell Disease with parenting.

MCSHC also contracts with IHTC to provide outreach to Amish persons with bleeding disorders. The program provides home visiting, health care services, an annual health clinic and factor concentrate to those affected.

Indiana Birth Defects and Problems Registry (IBDPR) is a population-based surveillance system that seeks to promote fetal, infant, and child health, in order to prevent birth defects and childhood developmental disabilities, and to enhance the quality of life of affected Indiana residents. IBDPR collects data on all children in Indiana from birth to age three with congenital anomalies or disabling conditions and up to age five for children with fetal alcohol syndrome and autism. The information provided by the registry has the potential to uncover the environmental causes of defects, thus preventing future cases.

The data collected for IBDPR is used to (1) detect trends in birth defects and suggest areas for further study, (2) address community concerns about the environmental effects on birth outcomes, (3) evaluate education, screening, and prevention programs and (4) establish efficient referral systems that provide special services for the children with identified birth defects and their families.

Indiana State Law requires a screening test for possible drug affliction in certain newborns. Hospitals and physicians are required to submit a meconium specimen for every infant who meets the selection criteria to test for Amphetamines, Cannabinoids, Cocaine and Opiates. MCSHC contracts with a central lab to provide this screening for the state. MCSHC keeps the data from this program but does not do tracking. Local hospitals and the physicians are responsible to refer the mothers and infants for appropriate treatment, social services and early intervention.

2. Children
MCSHC provides preventive and primary care for children through 15 grants to agencies that provide direct medical services and enabling services to children and 6 adolescent health care programs. Many of these grantees are community health centers or are a part of a larger health care facility. They provide direct health care services and health and safety education. Using AAP guidelines and Bright Futures, MCSHC has developed Standards of Care for children 0-21 years of age.

MCSHC administers the Indiana Child Care Health Consultant Program (ICCHCP) through funding provided by FSSA from the Child Care Development Block Grant. MCSHC contracts with an outside entity to provide health education and technical assistance to licensed and unlicensed child care providers serving children 0-8 years of age. ICCHCP is contracted to hire and/or subcontract, educate and supervise qualified community based child care health consultants, identify out-of-home child care providers and develop an infrastructure linking them with child care health consultants in their local community and to identify, recruit, educate, certify, and provide oversight to professional child care health consultants and health advocates. ICCHCP collaborates with other health and safety providers in the state and with injury prevention efforts within ISDH.

MCSHC is developing Early Childhood Comprehensive Services (ECCS) through a grant from MCHB to plan a coordinated, comprehensive, community-based system of services for young children from birth through age five and their families. ECCS is a collaborative process across public and private organizations. Core Partners include ISDH, FSSA, Indiana Department of Education (IDOE), Indiana Department of Corrections (IDOC), Indiana Department of Environmental Management (IDEM), the Indiana Parent Information Network (IPIN), Indiana Association for the Education of Young Children, Indiana Head Start Association, and Riley Hospital for Children/Child Development Center. Additionally, five Subcommittees were formed and met to address the project's five focus areas which include: access to health insurance and a primary medical provider; mental health and socio-emotional development; early care and education; parent education; and family support. An application for implementation funding with a strategic plan has been submitted to MCHB.

The Oral Health Division (OHD) of the ISDH Community & Family Health Services Commission focuses on education and prevention with a special emphasis on fluoridation. This program is funded by Title V. Oral Health staff provide technical assistance and surveillance to communities and schools with fluoridated water supplies. MCSHC supports the OHD community-based pit and fissure sealant program. This program's objectives include (1) promoting the use of sealants throughout Indiana and working toward the national health objective to have 50% of children with sealants by Year 2010, and

(2) promoting the cooperation of Indiana dentists, dental hygienists, and dental assistants in community dental health programs. MCSHC continues to provide partial funding for the Indiana SEAL program, providing a mobile unit to bring these services to children across the state.

In addition to their fluoridation efforts, Oral Health is the investigative authority regarding universal precautions and infectious waste management issues as they pertain to delivery of oral health services; legislatively mandated to annually survey a percentage of Indiana licensed dentists as to the effectiveness of the routine biological testing of their autoclaves; promotes the P.A.N.D.A. program (Prevent Abuse and Neglect through Dental Awareness) by providing educational presentations to local dental societies and organizations throughout the state; provides educational materials relative to Oro-facial Injury Prevention as requested. Additionally, MCSHC funds a grantee to provide a dental clinic for Amish children in northern Indiana to provide dental care, achieve optimal fluoridation, and increase awareness of oral health and disease.

MCSHC Medical Director Dr. Judith Ganser coordinates Addressing Asthma from a Public Health Perspective in conjunction with Indiana Department of Environmental Management. The Asthma Program organized the Indiana Joint Asthma Coalition and developed a state Asthma Plan. OMPP and ISDH provide an Asthma case management program for Medicaid clients.

The MCSHC Adolescent Health Program works to improve Indiana adolescent health status regarding six major health risks (see YRBS below) and to increase Indiana adolescent access to primary health care services. The State Adolescent Health Coordinator manages the Indiana Reduces Early Sex and Pregnancy by Educating Children and Teens (RESPECT) program that includes sexual abstinence education and adolescent pregnancy prevention programming as well as providing programmatic consultation to five Title V funded school-based adolescent health centers. MCSHC works in collaboration with other public and private entities (including the American Legacy Foundation Statewide Youth Movement Against Tobacco Use) to design, develop, and implement statewide initiatives to improve adolescent health, and coordinates the collection of the Indiana Youth Risk Behavior Survey.

Indiana RESPECT uses State Adolescent Pregnancy Prevention funds and Federal Sexual Abstinence Education Block Grant funds to fund three components: (1) community grant program, (2) community grant program evaluation, and (3) a statewide media campaign. Specific grant applications solicit proposals for the distinct State and Federal funding programs. Grantees provide these programs in a variety of youth-serving organizations including schools, faith based organizations, and community organizations. Montgomery, Zukerman, and Davis, an Indianapolis advertising agency, will implement and measure the effectiveness of Indiana's statewide sexual abstinence and adolescent pregnancy prevention media campaign. Free broadcast-quality copies of the media materials are provided to local communities for local campaign initiatives and local media scheduling. Awareness and recall of the media campaign will be assessed by telephone surveys completed with Indiana teens and parents after each broadcast flight of the TV and radio spots.

MCSHC Youth Risk Behavior Surveillance System (YRBS) is part of a national survey effort by CDC to monitor student health risks and behaviors in six categories identified as most likely to result in negative outcomes. YRBS was designed to determine the prevalence of health risk behaviors among youth; to assess whether health risk behaviors increase, decrease, or stay the same over time; and to examine the co-occurrence of health risk behaviors. The categories in the survey include: Tobacco Use , Alcohol and Other Drug Use, Unintentional Injuries and Violence, Adolescent Sexual Behavior, Weight and Nutrition , and Adolescent Physical Activity. The survey provides comparable state, and national data, as well as comparable data among subpopulations of youth. Health officials can use the data to monitor progress towards achieving the U.S. Department of Health and Human Services' Healthy People 2010 objectives, as well as to guide health programs. The sample collected for 2003 and 2005 was large enough for a weighted analysis of the data.

3. CSHCN
Within MCSHC, the Children's Special Health Care Services (CSHCS) program provides financial

support for primary, preventive and specialty care including physician and hospitalization for services due to the eligible diagnosis for CSHCN statewide. The Authorization Unit completes prior authorization for services from providers. The Customer Service Unit assists clients with programmatic questions and facilitates the program's services and using the Indiana Family Helpline (IFHL) for referrals to other services. CSHCS and IFHL provide access to hearing impaired and non-English speaking clients through a TTY number and translation services available within IFHL. CSHCS provides regular training to County Offices of Family and Children (OFC) staff throughout Indiana regarding the use of CSHCS services and the Combined Enrollment Form -- a common intake for CSHCS, First Steps and Medicaid used by OFC and First Steps. This training emphasizes identification of and outreach to eligible children. The CSHCS Program reimburses Family and Social Services Administration (FSSA) for local OFC staff to take CSHCS applications, gather verifications, and send applications to ISDH for eligibility determination.

The Hemophilia Program pays premiums for a state insurance program, the Indiana Comprehensive Health Insurance Association (ICHIA), for children and adults diagnosed with hemophilia or von Willebrand disease who meet the program criteria. As applicable, premiums are paid by CSHCS or Chronic Disease.

a. Rehabilitation
CSHCS coordinates with the Supplemental Security Income (SSI) program to inform SSI recipients and applicants about CSHCS. CSHCS receives referrals from SSI to provide services for blind and disabled individuals under age 16 and sends information about CSHCS to those SSI recipients not already enrolled. SSI enrollment data is collected by Systems Points of Entry (SPOE) data system in First Steps and by the CSHCS HIPAA compliant data collection system, Agency Claims Administration Processing System (ACAPS) which tracks participation in SSI.

b. Community-Based Care
CSHCS customer service staff are trained insurance experts, assisting families through insurance procedures to maximize coverage and eliminate gaps in service. CSHCS works to link clients to local primary care providers and specialty providers where possible. CSHCS works through the Indiana Parent Information Network to provide assistance to families of children with special health care needs as well as to professionals to disseminate information on community resources and systems of care.

4. Culturally Competent Care
MCSHC encourages all grantees (especially those in areas with large or growing minority populations) to work with local Minority Health Coalitions to develop culturally competent staff and materials. The ISDH Office of Cultural Diversity and Enrichment addresses the public health needs of minorities in Indiana by offering a two-day training session in cultural competency to all employees of ISDH and to local health professionals and grantee staff twice per month as well as a monthly advanced workshop. This office also distributes and analyzes a minority health disparity survey ISDH requires for all contractors. If contractors do not meet ISDH cultural competency goals, ISDH seeks alternate contractors.

The ISDH Office of Minority Health (OMH) works with state groups working with minority populations. These include Indiana Minority Health Coalition, IPN, and Indiana Latino Institute. ISDH OMH works with the Indiana Minority Health Coalition, Indiana University School of Medicine (IUSOM), Eli Lilly & Co., and others to increase the number of minorities drawn to health careers through scholarships, mentoring, early introduction of the health sciences, and additional preparation support.

C. ORGANIZATIONAL STRUCTURE

The Honorable Mitchell E. Daniels, Jr. (R) was sworn in Jan. 10, 2005 as Indiana's 49th Governor. Daniels replaces Joseph Kernan (D) after a hard-fought gubernatorial campaign. State Health

Commissioner Gregory Wilson, M.D., resigned in January. In February 2005, Dr. Judith Monroe was appointed State Health Commissioner, the first woman to head the Indiana State Health Department. Monroe was director of the Primary Care Center and Family Medicine Residency Program at St. Vincent Hospitals in Indianapolis since 1992. She earned her medical degree from the University of Maryland and formerly worked as director of clinics with the Indiana University School of Medicine's Department of Family Medicine. Commissioner Monroe will also serve as medical director for the state's Medicaid program. This marks the first time the two agencies responsible for regulating and paying for the health care of the state's residents have had a direct connection.

The Indiana State Department of Health (ISDH) is one of several major departments in state government. ISDH has four commissions overseen by the State Health Commissioner and Deputy Health Commissioner Sue Uhl, J.D., also appointed in February 2005.

The Operational Services Commission oversees three special institutions: Indiana's Soldier and Sailor's Children's Home, Indiana Veterans' Home, and Silvercrest Children's Developmental Center. Operational Services also provides Finance, Facilities Coordination and other administration for ISDH. The new Senior Director of Finance, Lance V. Rhodes, manages this commission under the authority of the Deputy Commissioner.

The Information Services and Policy Commission lead by Assistant Commissioner: Joe Hunt, M.P.H., houses Information Technology Services (ITS), Epidemiology Resource Center (ERC), ISDH Laboratories, External Information Services (EIS), Public Health Preparedness, Utility Services, Vital Records, Office of Policy, and Quality Improvement/Statistics.

The Health Care Regulatory Commission under Assistant Commissioner Terry Whitson, J.D., regulates Acute Care facilities, Long Term Care Facilities, Consumer Protection, Medical Radiology Services, Sanitary Engineering, and Weights and Measures.

The Community & Family Health Services Commission houses MCSHC, WIC, Community Nutrition, Local Liaison Office with local health departments, Chronic/Communicable Disease, Immunization, Human Immunodeficiency Virus/Sexual Transmitted Disease (HIV/STD), Quality Improvement, Oral Health, and Primary Health Clinics. The new Assistant Commissioner is Loren Robertson, M.S., R.E.H.S., formerly Administrator of the Fort Wayne/Allen County Health Department.

MCSHC is responsible for administering and coordinating all parts of the Title V Block Grant for Indiana. The MCSHC Administrative Director position is vacant. MCSHC Medical Director, Judith A. Ganser, M.D., M.P.H., serves as interim director along with Assistant Director Edward M. Bloom.

MCSHC distributes Title V Federal-State Block Grant Partnership budget primarily through grants to community agencies that provide direct, enabling, population-based, and infrastructure building services that impact the federal and state performance measures.

MCSHC Health Systems Development (HSD) includes subject matter experts who coordinate several MCSHC programs. HSD works closely with MCSHC Business Management to implement parts of these programs through grants and contracts. HSD consultants provide training and technical assistance to MCSHC grantee agencies and individually facilitate programs such as Indiana Family Helpline (IFHL), Prenatal Substance Use Prevention Program (PSUPP), Indiana Reduces Early Sex and Pregnancy by Educating Children and Teens (RESPECT), and the Free Pregnancy Test Program (See Section B). HSD consultants build health services infrastructure with community organizations within their assigned counties. See attached HSD consultant county assignment schedule and map. One HSD team leader also serves as MCSHC Training Manager to facilitate training opportunities for MCSHC staff, other ISDH employees and grantee staff. One HSD consultant oversees the ICCHCP and another oversees PSUPP and IFHL.

Grant programs funded by MCSHC using Title V funds include: Indiana Women's Prison Families Project, Statewide Healthy Families Abuse Prevention, Statewide Family Planning Monitoring and

Data Collection, Statewide Perinatal Health Care Planning, Statewide Suicide Prevention, 13 Prenatal Medical Care Clinics, 13 Infant Health Care Clinics, 15 Child Health Care Clinics, 5 School Based Adolescent Health Clinics, 4 Women's Health Care Clinics, 4 Children and Families Dental Services Programs, 23 Prenatal Care Coordination Programs, 13 Family Care Coordination Programs, 11 Family Planning Programs, 4 Childhood Obesity Programs, 5 Genetics Clinics, 3 Prenatal Genetics Programs, 2 Lead Poisoning Prevention Programs, 7 Community Needs Assessment Projects, 3 Fetal Infant Mortality Review Projects, and a number of pilot projects designed to test new approaches to health service delivery and infrastructure building. MCSHC also uses Title V to provide partial funding for several PSUPP clinics, the Indiana Poison Control Center, some RESPECT projects, prophylactic penicillin for children with Sickle Cell disease, an outreach program for Amish families with bleeding disorders, and the production of technical manuals and training programs for MCSHC staff and grantees.

Some programs including the Newborn Screening Program, Meconium Screening for Drug-Exposed Newborns Program, Newborn Hearing Screening Program, IFHL, Free Pregnancy Test and some population-based educational campaigns, including the Folic Acid Awareness Campaign, are directly administered by MCSHC. HSD and Newborn Screening are under the direction of Nancy Meade, R.D., M.P.H., MCSHC Health Planner/Programs Manager, who also co-chairs the needs assessment process.

MCSHC Data Analysis section provides data entry, technical support, and data analysis. The Data Analysis team gathers the majority of the data for the Title V annual report as well as the needs assessment process. The team also contributes to the Data Integration Steering Committee that is responsible for overall data integration and data sharing efforts agency-wide. The data gathering effort involves collecting data from programs and agencies ranging from Indiana State Police (demographic data regarding truancy and arrests of minors) to the Department of Education (school attendance and enrollment information) to all MCSHC projects and clinics (clients served in various programs) and more in order to provide detailed data required for the Title V Block Grant. The Data Analysis Section also maintains the MCSHC portion of the ISDH web page.

MCSHC Business Management manages all contracts and grants, prepares Grant Application Procedures (GAP), facilitates review of grant and contract applications, and monitors grant and contract expenditures. This section makes Title V budget planning recommendations and coordinates all applications for funding including primary responsibility for preparing the Title V grant application and annual report narrative. MCSHC Business Management coordinates all contracting, procurement and programmatic financial tracking as well as providing a clerical support pool for the division.

The MCSHC Administrative Director directly supervised the CSHCN program, providing customer service, eligibility, authorization, and claims for the State. CSHCN program services are provided through three teams: Eligibility, Prior Authorization, and Claims. Additionally, the separate Cultural Diversity and Enrichment program collocated with Prior Authorization provides training and technical assistance for health care professionals and cultural competence training for MCSHC staff and grantees.

D. OTHER MCH CAPACITY

The MCSHC management team consists of the Administrative Director (vacant), Medical Director (a pediatrician with a Masters of Public Health), Assistant Director, MCH Health Planner/Programs Director, Cultural Diversity & Enrichment Director, CSHCS Claims Director and CSHCS Eligibility Director. See attached organizational chart.

The Assistant Director (BS business management, CGSC military science) with business and automation skills coordinates personnel and facility issues and supervises the Data Analysis and Business Management team leaders.

The Data Analysis Section headed by a Public Health Administrator with a BS in Elementary Education and 20 years data analysis experience, provides data entry and analysis for MCSHC. This section includes a secretary, a data entry clerk, and a contracted technical consultant/web designer.

The Business Management Section, under a Grants Coordinator with a BS (general education) and 12 years grant management experience, coordinates contracting, financial tracking, grant application and provides a clerical pool. This section includes a Program Coordinator and an Administrative Assistant, both with more than 15 years experience with State government and three clerical/data entry staff.

The MCH Health Planner/Programs Director, an RD and MPH with more the 30 years experience in maternal and child health, supervises the MCH Health Systems Development and Genomics in Public Health / Newborn Screening section team leaders.

Three HSD Teams Leaders (one with a PhD and MSW, one with BS in English & Psychology and one with BS Public Administration) coordinate the HSD team of three Chief Nurse Consultants (one RN, MSN for prenatal health, one RN, MS for early childhood and one vacant position), a MSW/LCSW HSD Consultant, the State Adolescent Health Coordinator (MPH) and the Indiana Family Helpline Program Coordinator (BA, MS, CIRS) who leads a team of 5 state and 6 contract data and clerical staff.

The Genomics/Newborn Screening Director (MS, CGC) supervises two RN Chief Nurse Consultants, a Public Health Administrator, Social Services Specialist, Secretary and 2 clerical staff as well as a contracted State Audiologist. In addition she oversees, a Public Health Administrator who coordinates IBDPR and the vacant State Genetics Specialist position and 2 contracted Genomics Program Consultants -- one RD and one Genetics Counselor (MS, ABGC eligible). MCSHC is in process of transitioning these two contractors into state positions.

The CSHCS management team includes the Eligibility Manager (RN), a Claims Manager (BS), and one RN/MSN who coordinates Prior Authorization and the cultural diversity and enrichment program.

CSHCN Eligibility has 2 RN Public Health Nurse Consultants, 2 RN Welfare Nurse Consultants, 2 Welfare Consultants, 8 secretaries and 2 clerical staff. Prior Authorization has 3 RN Public Health Nurse Consultants, 2 Welfare Consultants, a Social Services Specialist, Environmental Scientist and an Administrative Assistant. Claims has a Program Director (vacant), a Health Planner, 2 Social Services Consultants, 2 Program Coordinators, 2 account clerks, a Social Services Specialist, 5 clerical staff and 2 secretaries.

MCSHC staff includes approximately seven parents or grandparents of children with special health care needs. Two are in NBS and four are part of the IFHL, including the IFHL coordinator. MCSHC, through a contract with the Indiana Perinatal Network, Inc., supports a SIDS parent who runs the SIDS program in Indiana. A contract with Indiana Parent Information Network also supports parent involvement.

MCSHC also supports one dentist, a dental hygienist, four fluoridation staff and two secretaries in the Oral Health Program; one lawyer in ISDH legal department; two Information Technology Services staff plus three contractual positions in ITS; and one Epidemiology Resource Center professional.

E. STATE AGENCY COORDINATION

Public Health Relationships
The public health system in Indiana includes ISDH and 94 autonomous local health departments (LHD) that are functions of county or municipal government. MCSHC coordinates with the ISDH LHD

liaison office and local health departments to facilitate development of health systems in counties of need. MCSHC provides Title V funding to Marion, Lake, St. Joseph, and Allen counties for FIMR projects. Title V funding to other LHD MCH programs promotes direct services clinics, enabling case management services, infrastructure building services and population based services through free pregnancy testing programs and media campaigns.

ISDH MCSHC works with other parts of ISDH through informal and formal staff assignments, collaborative initiatives, technical assistance, development of policy, state plans and funding of programs. These include coordination with the Lead Prevention Program to develop policy and programs and Title V funding of a prenatal lead testing program, sitting on the State Immunization Program Committee, funding of the statewide Dental Sealant Program, and population based surveys through the Oral Health Department and the IU School of Dentistry, sharing of educational materials, and providing technical assistance to the Division of HIV/STD, Office of Cultural Diversity and Enrichment to provide mandatory cultural competence trainings for all Title V funded projects, Newborn Screening, co-location of clinics and shared funding with the Office of Primary Care and work to integrate MCSHC programs with FQHC & CHC programs, and WIC and Community Nutrition programs to develop a state breastfeeding plan, chronic disease asthma program, and a state obesity prevention program. All of these ISDH divisions are housed alongside MCSHC within ISDH Community & Family Health Services Commission.

MCSHC also works with ISDH departments outside of the Community and Family Health Services Commission including collaboration with Epidemiology staff to develop the Operational Data Store (ODS) to create a common health status database to collect health status and services information across several program areas and provide for more comprehensive data analysis, Vital Records, the Office of Minority Health to address disparity issues, and the Office of Women's Health education and planning.

MCSHC has an ongoing relationship with the Bioterrorism Preparedness Program within ISDH. MCSHC collaborated with the ten public health preparedness district epidemiologists to collect assessment data on each county and Systems Development consultants were reassigned counties to correspond with the ten public health preparedness districts.

MCSHC provides partial funding for the Indiana Poison Control Center (IPC), operated by Clarian Health Partners. IPC provides statistical data to MCSHC and also by contract provides epidemiological surveillance for potential bioterrorism or chemical disaster clusters by region, nature and frequency of incident reports.

Relationships with Social Services
The Indiana Family and Social Services Administration houses the Division of Family Resources which encompasses Temporary Assistance to Needy Families (TANF), food stamps, child care, foster care, adoption, homeless services, and job programs; the Division of Disability and Rehabilitative Services which encompasses in-home services, deaf and hard-of-hearing services, blind and visually impaired services, and social security disability eligibility; the Division of Mental Health and Addiction, and the Office of Medicaid Policy and Planning.

ISDH and FSSA share data through a Memorandum of Understanding (MOU) that addresses general areas of collaboration and data interchange as well as specific issues like reimbursement for lead lab tests and IFHL outreach for FSSA services for children with special health care needs who are eligible for both Hoosier Healthwise and CSHCS. This includes eligibility for SSI through the FSSA Disability Determination Bureau and services through the FSSA Vocational Rehabilitation Services.

MCSHC coordinates with Indiana Family and Social Services Agency (FSSA) to expand Hoosier Healthwise (Medicaid) coverage, develop comprehensive early child care systems including the Early Childhood Comprehensive Systems Program (ECCS) and the Indiana Child Care Health Consultant Program (ICCHCP), provide partial funding for the Healthy Families program and receive funding for the PSUPP.

The MCSHC Medical Director serves on the First Steps Interagency Coordinating Council and the Board for the Coordination of Child Care with FSSA staff and other state agencies and consumers.

ISDH and FSSA coordinate with WIC, CSHCS and First Steps to reduce duplication and ensure coverage for all eligible infants and children. CSHCS and FSSA provide joint planning, outreach and training for county systems points of entry to determine Medicaid and/or CSHCS eligibility. MCSHC standards of care for prenatal care coordination and child health programs require developmental screening and referral to First Steps for children age 0-3.

MCSHC staff serves on FSSA's Indiana Head Start Partnership Project Advisory Council. Federal funding from DHHS, Administration for Children and Families has enabled Head Start programs to provide comprehensive services for low-income Hoosier children and their families for over 35 years.

MCSHC requires all grantees to provide EPSDT and accept funding from Medicaid as payment in full. Medicaid provides reimbursement for EPSDT.

MCSHC houses the Prenatal Substance Use Prevention Program (PSUPP) with partial funding from Title V, FSSA Division of Mental Health and Addiction, and Indiana tobacco Prevention and Cessation (ITPC). PSUPP works to prevent poor birth outcomes by helping women to decrease or cease alcohol, tobacco and other drug use during pregnancy. PSUPP is implemented statewide through the efforts of a MCSHC state program director, fifteen local projects and an evaluation team. The local directors collectively serve, but are not limited to, constituents from twenty-two Indiana counties that include: Allen, Clark, Dearborn, Dubois, Delaware, Elkhart, Franklin, Jennings, Lake, LaPorte, Madison, Marion, Ohio, Owen, Putnam, Ripley, Spencer, Switzerland, Tippecanoe, Vanderburgh, Vigo, and Warrick.

MCSHC supports efforts to promote education and screening for perinatal depression. The Indiana Perinatal Network received a three-year continuation grant from HRSA to develop a perinatal depression state plan, including provider training and protocols.

MCSHC provides partial funding for Healthy Families Indiana (HFI), a voluntary home visitation program designed to promote healthy families and healthy children through a variety of services, including child development, access to health care and parent education available in all 92 counties. Part of Healthy Families America, HFI provides support to families with their first newborn whose hospital or prenatal screens indicate that they are at risk for child abuse. HFI is also funded by FSSA and the Indiana Criminal Justice Institute and receives additional support through TANF funds, a specialized license plate, Kids First, and other sources.

MCSHC receives funds from FSSA to coordinate the ICCHCP that provides consultation on health and safety issues to child care providers by site visit and phone and provide health and safety information, educational materials and contact information via the internet, access to resources, reports and data on the website.

The new State Health Commissioner also serves as Medical Director for the State Medicaid program--appointed to that position by the Governor to better coordinate ISDH and Medicaid policy. MCSHC coordinates with FSSA Office of Medicaid Policy and Planning (OMPP) to expand Hoosier Healthwise (Medicaid) coverage. Many Title V grantees became Medicaid enrollment centers for Hoosier Healthwise when the State expanded the program for SCHIP.

As of July of 2005 all Indiana Medicaid participants, except those with disabilities in the Medicaid Select program will be enrolled in mandatory Medicaid Managed Care Organizations (MCOs). OMPP has contracted with five MCOs to cover the state. MCSHC has been working with OMPP and the MCOs to ensure that targeted case management services remain available to meet the needs of pregnant women, infants and families.

Indiana Prenatal Care Coordination (PNCC) identifies pregnant women who are eligible for Title XIX and Title XXI and helps them apply for services. PNCC has been a Medicaid reimbursable service in Indiana since 1990. Services include outreach and case finding, home visit assessments per trimester, care plan monitoring, education, and referral to needed services. MCSHC funds local agencies and hospitals to provide prenatal care coordination in areas where mothers are at high risk for poor pregnancy outcomes. MCSHC provides technical assistance, training and oversight to funded and non-funded prenatal care coordination programs in Indiana. MCSHC works closely with the federally funded Healthy Start Programs outreach and case management initiatives in Indianapolis and Lake County.

MCSHC collaborates with the Indiana Chapter of the National Association of Social Workers to provide certification training to nurses and social workers applying to become prenatal care coordinators.

With the entrance of Medicaid Manage Care in Indiana MCSHC found the PNCC program in jeopardy as MCOs wanted to provide care coordination services over the phone. MCSHC staff met with OMPP and the MCOs to assure that the Medicaid PNCC continued to be utilized and continued to receive reimbursement for services as stated in Indiana Code 405 IAC 1-7-24.

MCSHC staff collaborated with OMPP and the MCOs to revise the State Prenatal Risk Assessment Tool, and works to standardize assessment and report tools, revise training of prenatal care coordinators, program evaluation, and also participates in the revision of the Medicaid Code on prenatal care coordination reimbursement. At least three training events, directed to local prenatal care coordination providers, are planned in cooperation with OMPP and the MCOs to educate providers on new tools, how to contract with MCOs, billing and reimbursement under MCOs.

Relationship With Other State Agencies
MCSHC funds Indiana School for the Deaf (ISD) to support EHDI programs by providing training materials, a video project and regional audiologists to outreach to hospitals, audiologists and First Steps programs statewide to identify, promote, support and educate families with infants newly diagnosed with hearing loss in language development.

MCSHC receives funds from Indiana Department of Education (IDOE) to perform the Youth Risk Behavior Study (YRBS) to identify and reduce high-risk behaviors among school age children. ISDH partners with IDOE to improve the health of Indiana children through the schools. IDOE has received a 5-year grant from the Centers for Disease Control and Prevention to bring the Coordinated School Health Program model to Indiana. The grant includes staff members in both state agencies.

MCSHC provides technical assistance for school programs, policy and environmental change, educational strategies based on CDC guidelines and coordination of resources. This program has eight interactive components: Health Education, Physical Education, Health Services, Nutrition Services, Counseling, Psychological, & Social Services, Healthy School Environment, Health Promotion for Staff, and Family/Community Involvement. The key focus areas are obesity, nutrition, physical activity, chronic disease, and alcohol, tobacco, and other drugs.

MCSHC has developed a coalition that includes IDOE, to implement the Early Childhood Comprehensive Systems program to create an integrated, coordinated, comprehensive system of services for children from birth to five. This initiative will help to ensure that a holistic system of care supports young children so they arrive at school ready to learn.

MCSHC works with the Indiana Department of Corrections through coalitions, and programs that provide services to prevent child abuse such as IHF, and the ICCHCP. MCSHC funds the Indiana Women's Prison's Responsible Mothers/Healthy Babies program to build and preserve the mother/child/family bonds while women are in prison.

Relationships With Universities

Over the years MCSHC has developed a relationship with the Indiana University Schools of Medicine and Nursing, and the new Department of Public Health. MCSHC collaborates with Indiana Perinatal Network (IPN) and with these educational institutions to develop, sponsor, and coordinate training events for health care professionals in public and private health settings.

MCSHC contracts with IU professors to evaluate pilot programs and conduct focus groups and town meetings around the issue of perinatal disparities. MCSHC has a long relationship with the IU Bowen Center to provide statistical evaluation of the PSUPP program and other funded initiatives. This year the Director of Adolescent Medicine will evaluate Indiana's RESPECT programs.

MCSHC links with state universities through the Masters of Public Health Program at Indiana University (IU) and the Center for Public Health Leadership and Education. Medical students from the IU Medical School are provided with preceptors for a public health rotation. Riley Infant and Childhood Nutrition Fellows at Clarian's Riley Hospital for Children are provided Title V background information. The MCSHC Medical Director serves on the advisory board for the MCHB funded Adolescent Health Training Program, Riley Child Development Program, and Behavioral Pediatrics Program.

MSCHC works with IU School of Dentistry (IUSD) to provide the statewide Dental Sealant Program. Title V and Children's Oral Healthcare Access Program (COHAP) funds support a mobile dental unit to provide school-based dental sealants in rural areas, particularly those near community health centers. Student dentists and hygienists staff the unit. MCSHC also provides funds to IUSD to support the craniofacial reconstructive surgery unit for children born with dental deformities including cleft palate.

Indiana Minority Health Coalition
MCSHC collaborates with the Indiana Minority Health Coalition (IMHC) to provide consultation for MCSHC grantees. MCSHC funds prenatal care coordination (case management) and support services for pregnant minority women in two of the most populous counties as part of the effort to lower minority infant mortality and disparity. Through 15 local Minority Health Coalitions, IMHC provides an immunization outreach program that works with local health departments and MCSHC projects to provide immunizations and health care. The IMHC Director also serves on the Steering Committee of Core Partners for ECCS.

MCSHC collaborates with local minority coalitions in Indianapolis, Gary, South Bend, Fort Wayne, Elkhart and Evansville to assist with development of local coalitions to address local perinatal disparity issues, conduct town meetings, work with faith based organizations to provide culturally competent services to African American families.

Helpline
MCSHC Indiana Family Helpline (IFHL) is a partner in IN211, Inc. IFHL and MCSHC staff have participated in the development of IN211 because IFHL is the only statewide I&R service. IFHL also assists the IMHC hotline by providing the database software and data.

Indiana Perinatal Network
MCSHC implements several programs through the Indiana Perinatal Network, Inc (IPN). These include the Indiana Perinatal Systems Strategic Plan for the 21st Century, developed through a series of regional town meetings and state task force groups. IPN builds infrastructure, provides professional and public education on perinatal health issues and quality assurance standards of care for perinatal services in Indiana. IPN houses the Sudden Infant Death (SIDS) program and the MCSHC Breastfeeding Program and provides a statewide Advisory Board for program planning, Regional Perinatal Advisory Boards, a speaker bureau, and a multi-media public education campaign. IPN also publishes Indiana Perinatal News (IPN newsletter), the Indiana Prenatal Online Magazine http://www.indianaperinatal.org, consumer information, clinical practice alerts, critical reports, and consensus documents like the Indiana Prenatal Guide. MCSHC also funds IPN to operate a pilot project to provide and evaluate Doula services in Marion County and the Indiana Friendly Access program to identify best practices to increase satisfaction with and utilization of health care services

for low income pregnant women and children and to more clearly identify and address barriers to health care for pregnant women and families with young children.

Tertiary Care Centers
MCSHC funds a CSHCS satellite office at Riley Hospital to provide CSHCN and their families easily accessible and expedited entry to the CSHCS program. MCSHC funds the Riley Hospital Comprehensive High-Risk Newborn Follow-up Program to provide follow-up to children and their families who are at the highest risk, medically and developmentally, of morbidity or mortality and build community-based infrastructure for these fragile children.

IPN in collaboration with ISDH, ACOG (American College of Obstetricians and Gynecologists), the State Perinatal Advisory Board and Indiana hospitals that provide perinatal health care, developed a consensus statement on Levels of Hospital Perinatal Care in Indiana to establish criteria for risk-appropriate levels of hospital obstetric and neonatal care and provide recommendations for appropriate consultation, referral and transport. There are a total of five full Level III Obstetric Hospitals in Indiana: IU Hospital, Methodist Hospital, St. Vincent Hospital, and Wishard Hospital in Indianapolis, and Memorial Hospital in South Bend. Riley Children's Hospital and St. Vincent Hospital in Indianapolis have the only two Level III/D Neonatal Intensive Care Units in the state. However, a total of six other hospitals are considered Level III/Subspecialty B-C. These are located Indianapolis, South Bend, Evansville, Newburgh, Muncie and Fort Wayne. IPN provides the Perinatal Continuing Educational Program (PCEP), a comprehensive program for those involved in the clinical bedside care of obstetrical and neonatal patients that teaches concepts and skills important to the care of high risk patients as well as patients stabilized prior to transfer to a sub-speciality center. The PCEP coordinator sets up training with one of the tertiary centers that then invite neighboring Level I and II hospitals to participate in the training program. The Level I and II hospitals are encouraged to create a MOU with the tertiary hospital to stabilize and transport high-risk pregnant women and neonates.

Family Planning
MCSHC contracts with the Indiana Family Health Council, Inc. (IFHC), a private not-for-profit agency that serves as the Title X grantee, to monitor the Title V family planning agencies. The contract also allows Title X to provide training and technical assistance to Title V family planning agencies.

After several years of trying a collaborative effort between family planning agencies, IPN, Indiana Access, and MCSHC have facilitated the passing of a Medicaid Family Planning Waiver that will provide family services to women on Medicaid up to two years after delivery. MCSHC will continue to work closely with Title X, IPN, and OMPP to facilitate initiation of the wavier.

Disabilities Services
CSHCS is now part of MCSHC. MCSHC routinely collaborates with the Office of Medicaid Planning and Policy (OMPP), Indiana Comprehensive Health Insurance Association, First Steps, SSI and Indiana Parent Information Network (IPIN) to ensure CSHCN have access to preventive, primary, and specialty medical and dental care. IPIN is contracted to ensure families are represented in service planning and delivery.

F. HEALTH SYSTEMS CAPACITY INDICATORS

SUMMARY OF HEALTH "SYSTEMS CAPACITY" INDICATORS
Reported Annually

#01 HEALTH SYSTEMS CAPACITY INDICATOR
The rate of children hospitalized for asthma (10,000 children less than five years of age)

Since 1990, the prevalence of asthma for children 18 and under has doubled in Indiana, and currently 8% of all Hoosiers have asthma, placing Indiana 14th in the nation in asthma prevalence.(L. Stemnock and J. Lewis, "Asthma Prevalence in Indiana," ISDH Epidemiology Resource Center/Data

Analysis Unit, 2001) However, the rate of Indiana children less than five years of age hospitalized with asthma has decreased from 76.0/10,000 in 2000 to 38.7/10,000 in 2003. This data was obtained from Indiana Hospital Discharge Data through the ISDH Epidemiology Resource Center. The reason for such a major reported decrease is greatly improved data from the Health and Hospital Corporation, whose discharge data was until 2003 based on projections that were overstated. Now that we have established a reliable means of getting accurate data, we will use 2003 as a baseline.

In October 2002, the Indiana State Department of Health (ISDH) and the Indiana Department of Environmental Management (IDEM) were awarded interagency funding by the Centers of Disease Control and Prevention's (CDC) National Asthma Program for capacity building and asthma plan implementation. In December 2004 the Indiana Joint Asthma Coalition, ISDH and IDEM published A Strategic Plan for Addressing Asthma in Indiana, a five-year strategy to begin addressing the burden of asthma in Indiana that includes a data surveillance plan. Currently, Indiana asthma surveillance involves the collection of prevalence, severity, and cost data using the Behavioral Risk Factor Surveillance Survey (BRFSS), Medicaid claims data, hospital discharge data, and mortality statistics. Each of these data sets has inherent limitations. For example, the BRFSS gives us data on adults only, patterns of health care are limited to Medicaid recipients, and hospital discharge data prior to 2002 was not individually identifiable which prevents trend analysis of hospitalizations.

The Data and Surveillance Workgroup of the Indiana Joint Asthma Coalition will work toward identifying gaps in present data sources describing the asthma burden and accessing additional data sources. Strategies of the workgroup include: 1) Solicit, inventory, and review the data needs, 2) Identify key users of asthma data in Indiana and review their data needs, 3) Identify gaps in present data collection and identify potential data sources to fill these gaps, and 4) Establish standardized data definitions, data analysis methods, and surveillance standards, utilizing nationally recognized definitions as applicable. In addition the workgroup will include geostatistical (GIS) analysis, the linkage of asthma prevalence with environmental data, and schools response in preventing and responding to asthma among students.

#02 HEALTH SYSTEMS CAPACITY INDICATOR
The percent of Medicaid enrollees whose age is less than one year during the reporting year who received one initial periodic screen.

The percent of Medicaid enrollees whose age is less than one year during the reporting year that received one initial periodic screen has increased from 69.8 percent in 2000 to 72.1 percent in 2003. We have been very successful in getting this information from Medicaid.

Indiana mandatory Managed Care for the MCH Medicaid population began phase-in transition in 2002. Managed Care prenatal care providers have been encouraged to assist the mother with enrollment of the baby with a managed care provider prior to delivery. In July 2005, five Medicaid Managed Care Organizations will cover all 92 counties in Indiana and will provide services for all Medicaid participants except those in Medicaid Select. The Indiana Prenatal Care Coordination program, and Healthy Families work closely with the MCOs and also assist in getting the infant into primary care. Performance data specific to each of the Hoosier Healthwise risk-based managed care plans will be published yearly by the Office of Medicaid Policy and Planning.

MCSHC funded clinics providing infant health care are required to report on MCH Performance Measure 6: Proportion of unduplicated clients receiving age appropriate number of comprehensive physical exams and screens during the fiscal year. The Numerator is the # of infants under 1 yr who received care from 3 months to 12 months of age who reached 12 months of age during the fiscal year who received > 4 periodicity visits.

#03 HEALTH SYSTEMS CAPACITY INDICATOR
The percent State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

In Indiana there were 225 SCHIP enrollees whose age was less than one year at the end of the fiscal year (Sept 2004). There were a total of 1,581 unduplicated SCHIP enrollees during the fiscal year who had at least one initial or periodic screen. From this data it is not possible to determine the total number of unduplicated SCHIP infants <1 year of age who had at least one periodic screen, as the figure available contains duplicates. Additionally this information was only provided by Medicaid in estimate form prior to the installation of Medicaid's new computer system. Beginning in 2004 we are receiving this actual, non-estimate data. 2004 will be used as baseline data. This measure has been subject to high variability in the past due to small numbers.

The low number of infants <1 year of age enrolled in SCHIP is attributed to the increase in infants eligible and enrolled in Medicaid. A decline in wages in some parts of the state has had an impact on Medicaid enrollment. Medicaid now covers some children who were covered by SCHIP due to declines in family income, which changed their eligibility status. Also, Indiana is one of six states that chose to eliminate twelve-month continuous eligibility in order to reduce state spending. This policy was implemented beginning July 1, 2002. Children are now required to recertify for Hoosier Healthwise every six months through a mail-in renewal application. If the application is not sent in, children lose their health care coverage and have to reapply to the Hoosier Healthwise program.

All of our funded MCH Projects are encouraged to become Medicaid/SCHIP enrollment centers to facilitate easy enrollment for eligible family members.

#04 HEALTH SYSTEMS CAPACITY INDICATOR
The percent of women (15-44) with a live birth whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

Early and continuous prenatal care is promoted through the Indiana Perinatal Network "Baby First Right From the Start" Media Campaign which promotes early prenatal care through billboards, free consumer videos, and print materials, the State Prenatal Care Coordination program which promotes early and continuous prenatal care utilization through outreach, education, and case management, and the MCH Free Pregnancy Test Programs which provides free tests to county agencies throughout the state. In return for free pregnancy tests agencies agree to assist all women with a positive pregnancy test into early prenatal care. There has been an increase in the use of community health workers and Baby First advocates providing outreach to pregnant women in targeted high-risk areas of the state with special project funding during FY 2005.

In 2003, 72.9% of all women in Indiana had adequate or adequate plus prenatal visits according to the Kotelchuck Index; 73.1% of White women, and 61.5% of Black women were observed to have adequate or adequate plus prenatal visits. The rate and the denominator for this figure are provided annually by the ISDH Epidemiology Resource Center; the numerator is then calculated.

The Office of Medicaid Policy and Planning has made the percent of women entering prenatal care in the first trimester a State Medicaid performance measure for State Medicaid MCOS.

#05 HEALTH SYSTEMS CAPACITY INDICATOR
Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

Until such time as Medicaid records are linked to Birth Certificate/Death Certificate records, the data on this form will be impossible to collect. Linkage of Medicaid records with Birth Certificate/Death Certificate records is in process, with a MOU in place and the Operational Data Store (ODS) in development. With the new Health Commissioner also now serving as Medicaid Medical Director, we anticipate receiving actual data from Medicaid. It is the intention of the ODS developers to design the ODS to be able to link between Medicaid and the ODS. This part of the ODS development is a key

objective for the near future. It is anticipated that by the end of FY 2006 it will be possible to have actual data for this form. Until then, estimates based on trend analysis will be reported.

#06 HEALTH SYSTEMS CAPACITY INDICATOR
The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0-1), children, and pregnant women.

The Office of Medicaid Policy and Planning under the Indiana Family and Social Services Administration administers Medicaid in Indiana. Indiana's Medicaid program covers pregnant women and children ages one and under, with family incomes up to 150 percent of poverty. Infants of mothers on Medicaid during the pregnancy are automatically eligible for Medicaid at time of birth.

Indiana's SCHIP was implemented in two phases. Phase I began on July 1, 1998 and expanded Medicaid eligibility. Phase II began January 1, 2000 and is a non-Medicaid program. Indiana's SCHIP is comprised of:

• Phase I SCHIP - Uninsured children below the age of nineteen with family incomes up to 150 percent of poverty. There are no monthly premiums for this category of recipients.

• Phase II SCHIP - Uninsured children with family incomes between 150 percent and 200 percent of poverty. Recipients in this category are required to pay a small monthly premium for coverage.

#07 HEALTH SYSTEMS CAPACITY INDICATOR
The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

Based on 2004 Medicaid data, there was a total of 108,112 EPSDT eligible children aged 6 through 9 at the end of the fiscal year, of these 70,321 children 6-9 years of age received any dental health service during the fiscal year or 65% of EPSDT eligible children received any dental health care. This is up from 39.4% in 2000.

The State slashed Medicaid dental reimbursements in 1994, which lead to a mass exodus of dentists from the Medicaid program, and a decrease in dental health services to Medicaid eligible children. Reforms in Indiana's Medicaid Dental Program in 2001 led to an increase in the number of dentists providing dental health services to Medicaid enrollees. Dental initiatives undertaken to promote utilization of dental services include Hoosier Healthwise educational brochures, referrals and advocacy from the MCSHC Indiana Family Helpline, MCSHC funding of the SEAL mobile to travel throughout the state and provide sealants to third grade students in school, requiring funded child health projects to report on the number of enrolled children receiving dental sealants, MCSHC funding of two dental health clinics within local health departments, and requirement of state funded community health centers to provide dental health.

#08 HEALTH SYSTEMS CAPACITY INDICATOR
The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program.

In FY 2003, the number of 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program was 2,406 out of a total of 14,690 children under 16 years old enrolled in the State CSHCN Program or 16.4%. This is an estimated figure based on the information now available on the SSI web site for Indiana as well as on defining rehabilitation services via specific diagnostic codes.

Indiana CSHCN Program provides rehabilitation services to children under the age of 16 receiving benefits under the SSI Program to the extent medical assistance for such services are not provided

through Medicaid. The CSHCS office provides Care Coordination, Eligibility, Prior Authorization (PA), Claims Processing, Provider Relations, and Travel Reimbursement support services for providers and participants or their families

#09(A) HEALTH SYSTEMS CAPACITY INDICATOR
The ability of States to assure the state Maternal and Child Health program and Title V agency access to policy and program relevant information and data.

Indiana continues to work on linkages as specified in the following seven areas: annual linkage of infant birth and infant death certificates, annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files, annual linkage of birth certificates and WIC eligibility files, annual linkage of birth certificates and newborn screening files, a hospital discharge survey for at least 90% of in-State discharges, an annual birth defects surveillance system, and a survey of recent mothers at least every two years similar to the PRAMS survey.

The Operational Data Store in the agency's main linkage mechanism. Progress has been made to such an extent that Indiana can now report successful linkage at least some of the time in all seven areas. MCSHC now has the ability to obtain data for program planning or policy purposes in a timely manner for all seven areas, and for birth certificate/death certificate information and the annual birth defects surveillance system MCSHC has that ability all of the time.

Access to the electronic databases for analysis has also been achieved with regard to the Newborn Screening link, the birth defects surveillance system link, and the survey of recent mothers (PRAMS like survey).

The plan is to continue work on the ODS including both input links and output via specific Data Marts in 2006.

#09(B) HEALTH SYSTEMS CAPACITY INDICATOR
The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the month.

Indiana high-school students are marginally more likely than their national counterparts to smoke cigarettes, according to the findings of the 2003 Indiana Youth Risk Behavior Survey conducted by the Indiana State Department of Health, MCSHC. Forty-eight high schools in the state and 1,674 students in grades 9 through 12 participated in the survey, which is part of a national study initiated by the Centers for Disease Control and Prevention to monitor student's health risks and behaviors. 2003 was the first time enough high schools in the state responded to the survey to allow the data collected to be weighted, that is, to be generalized for all Indiana high-school students. The Indiana Youth Risk Behavior Survey has been completed for 2005 with enough completed surveys to produce a weighted sample.

Fewer Indiana teens are smoking. The 2004 Indiana Youth Tobacco Survey (IYTS) shows that 21 percent of Hoosiers in grades 9-12 are smokers compared to 32 percent in 2000. This represents a 32 percent decline in smoking prevalence over the four-year period bringing Indiana's high school smoking rate below the national average.

The Indiana Youth Tobacco Survey was conducted from November 2004 to January 2005 surveying more than 5,400 Indiana youth in grades 6-12 at 92 schools statewide. The survey included an over sample of African American and Hispanic youth. Indiana Tobacco Prevention and Cessation (ITPC)

programs adapted the Youth Tobacco Survey, developed by the Centers for Disease Control and Prevention, by adding questions designed for Indiana to serve as a surveillance measure for statewide tobacco use prevalence among youth. The full 2004 Indiana Youth Tobacco Survey Report is available at www.itpc.in.gov.

#09(C) HEALTH SYSTEMS CAPACITY INDICATOR
The ability of States to determine the percent of children who are obese or overweight.

According to Trust for America's Health (TFAH), Indiana has the 15th highest overweight levels for high school students at 11.5 percent, and the 17th highest overweight levels of low-income children ages 2-5 at 12.7 percent in 2003. According to the 2003 Indiana Youth Risk Behavior Survey the percentage of students in grades 9-12 who described themselves as slightly or very overweight was 32.2%.

ISDH has created a new office of Community Nutrition and Obesity Prevention that has begun working on Indiana's strategic plan to combat child and adolescent obesity with the help of William Wishner, M.D., senior clinical research physician in endocrinology who was on loan from Eli Lilly as a special consultant. The plan, called "Sharing the Responsibility: Shaping the Future of Indiana Children," consists of five action areas: increasing awareness of obesity as a public health issue, promoting opportunities for lifestyle change, enabling legislation around nutrition and physical activity, monitoring obesity rates and related health conditions, and identifying stakeholders to support future work. In addition, Indiana is one of four states participating in a pilot study sponsored by the U.S. Department of Agriculture. The government has earmarked funds to provide students at 25 Hoosier schools with fruits and vegetables during non-lunch hours. The goal is to decrease the consumption of unhealthy snacks and increase student awareness of and preference for nutritious foods.

Measurement of BMI will take place through the Office of Community Nutrition and Obesity Prevention which has created a data assessment tool based on CDC guidance and has formed a team of key ISDH data-related staff as well as representatives from the IU School of Medicine Regenstrief Clinic to assess data needs, develop, modify, and/or maintain data collection system to monitor the prevalence, geographic distribution, and epidemiologic factors relating to overweight and obesity. In collaboration with IDOE the data team has developed collection guidance for the State school weight and height data collection scheduled to begin in the fall of 2005. WellPoint donated 4,000 pieces of collection equipment to ISDH for school use. The goal is for all Indiana schools to gather weight and height information on all students in K-12 grades. The data will be sent to DOE and BMIs calculated. Training for school nurses and parent volunteers on appropriate weight and height data collection will begin in July 2005 and schools will collect data from August to December 2005.

BMI data is also collected at all State WIC clinics and all MCSHC funded clinics. The implementation of the Body Mass Index (BMI) calculator, a stand-alone module created in 2005, and the revision of that module for Maternal and Child Health clinic use will enable the MCSHC clinics to collect and relay BMI data through the FRED system in relation to the obesity performance measure. MCSHC staff facilitated seven statewide BMI trainings for funded and non-funded providers in 2004.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The mission statement of the Indiana State Department of Health (ISDH) is to "promote, protect, and provide for the public health of people in Indiana". The ISDH vision statement affirms, "The Indiana State Department of Health is committed to facilitation of efforts that will enhance the health of people in Indiana. To achieve a healthier Indiana, the ISDH will actively work to: promote integration of public health and health care policy; strengthen partnerships with local health departments; collaborate with hospitals, providers, governmental agencies, business, insurance, industry, and other health care entities; support locally-based responsibility for the health of the community. The ISDH's vision for the future is one in which health is viewed as more than the delivery of health care and public health services. This broader public health view also includes strengthening the social, economic, cultural, and spiritual fabric of communities in our state.

In order to fulfill our mission, ISDH Maternal and Children's Special Health Care Services (MCSHC) continues to strive to meet the performance goals established by national initiatives such as MCHB's National Performance Measures as well as state initiatives, based on the latest needs assessment. The needs assessment results focused on the following health status indicators: Asthma Hospital Discharges, Medicaid/CHIP Screening, Prenatal Care Adequacy, Low/Very Low Birthweight, MCSHC Access to Data Sources, Fatal/Non-Fatal Injuries, Chlamydia Rates, Dental Screening, and Adolescent Tobacco Use.

The needs assessment results have dictated the focus of the State Priorities listed in the following section, "B. State Priorities". Program and resource allocation issues are determined using the State Priorities for guidance. Utilizing the MCH "pyramid", program and resource funding has been carefully allocated to cover not only the State Priorities but also to cover all four of the "pyramid levels".

Direct Health Care is being evaluated with performance measures (PM) for Newborn Screening, CSHCS Family Participation, and Asthma Hospitalization. Enabling Services PM include the CSHCS Medical/Health Home and decreasing tobacco use in prenatal smokers. Population based PM address CSHCS Insurance, CSHCS Community Systems, CSHCS Transition Issues, Immunization Rates, Teen Birth Rates, Dental Sealants, Child Motor Vehicle Accidents, and Lead Screening. Infrastructure Building PM include Breastfeeding Improvements, Newborn Hearing Screening, Child Health Insurance, Medicaid Usage, Very Low Birth Weight, Teen Suicide, High Risk Deliveries, Prenatal Care, Data Integration, Prenatal Care for Black Women, Birth Spacing, and Overweight Rates among High School Students. State and National Performance Measures have been established and hold ISDH MCSHC accountable for the success (or failure) of each of these initiatives.

Outcome Measure data for Infant Mortality, Black/White Infant Mortality Disparity, Neonatal Mortality, Postneonatal Mortality, Perinatal Mortality, and the Child Death Rate are also monitored and reported annually.

Specifically, within the "pyramid" level of Direct Medical Services ISDH MCSHC funds programs to provide genetics services, immunizations, dental sealants, sickle cell prophylactic medicine, lead poisoning prevention, direct medical care for pregnant women, infants, children, adolescents, family planning, STD screens, free pregnancy screens, as well as speciality medical services and primary care for CSHCN. Funded Enabling Services programs provide genetics services education, prenatal and family care coordination, newborn screening and referral, sickle cell management, prenatal substance use prevention program (PSUPP), Indiana Child Care Health Consultation Program (ICCHCP) and coordination with Medicaid and WIC in addition to many other programs. Population- Based Services that are provided by ISDH MCSHC or funded by MCSHC include the Indiana Family Helpline (IFHL), the Early Childhood Comprehensive Systems (ECCS) program, the Indiana Joint Asthma Coalition (InJAC), the adolescent pregnancy prevention initiative, sudden infant death prevention, dental fluoridation efforts, and fetal infant mortality review. ISDH Infrastructure Building Services include efforts such as the Indiana Perinatal Network; the MCH, NBS and PSUPP

data systems; the integration of data systems to facilitate the Indiana Birth Defects and Problems Registry (IBDPR), the Genomics in Public Health and Newborn Screening education efforts and other data analysis efforts for planning and reporting; policy and standards development; planning, evaluation, and monitoring; and quality assurance to MCSHC grantees.

Progress toward the achievement of our National and State performance goals is reported in Sections C and D following. ISDH MCSHC continues to build on previous year's successes. This year's Annual Report reflects that for 2004, ISDH MCHSC met eight of the thirteen National performance measures for which FY 2004 data is available, and six of the seven previous State-Negotiated performance measures have been met. Progress could not be reported on the five performance measures that are reported through the CSHCN survey, as current data is not available. Of the five national performance measures and the state-negotiated performance measure that were not actually met, most were close.

MCSHC is proposing a new set of State Negotiated Performance Measures (SP) based on the results of the needs assessment. Several of the new SP are identical to the previous SP, only the number has been changed. Others are similar in the need addressed, but the measure has been changed to keep up with MCSHC progress in addressing that need. There are three entirely new proposed SP and some of the previous SP are being discontinued. These are enumerated in Sections B and D.

B. STATE PRIORITIES

Indiana experiences high rates of low birthweight, infant mortality, and inadequate prenatal care with greater disparity among minority populations. Childhood immunizations, while significantly improving, are still below HP2010 targets and environmental hazards such as lead and second hand smoke threaten the health of tens of thousands of children and adults.
Risky behaviors among adolescents lead to teen pregnancy and childbearing and high rates of tobacco use. Obesity among children and adults contributes to higher incidences of chronic diseases like diabetes and cardiovascular diseases that contribute to escalating health care costs.
A high priority must be given to expanding the availability of care for isolated rural residents and underserved urban and suburban persons and to assisting the MCH populations access to needed services, including the continued need to identify early and link children with special health care needs to appropriate services. At the same time, broad based education and outreach is needed to improve knowledge of healthy practices among the entire population.

The top priority needs identified in Indiana are:
1. To decrease high-risk pregnancies, fetal death, low birth weight, infant mortality and reduce racial and ethnic disparities in pregnancy outcomes.
2. To reduce barriers to access to health care, mental health care and dental care for pregnant women, infants, children, children with special health care needs, adolescents, women and families.
3. To build and strengthen systems of family support, education and involvement to empower families to improve health behaviors.
4. To reduce morbidity and mortality rates from environmentally related health conditions including asthma, lead poisoning and birth defects.
5. To decrease tobacco use in Indiana.
6. To integrate information systems which facilitate early identification and provision of services to children with special health care needs.
7. To reduce risk behaviors in adolescents including unintentional injuries and violence, tobacco use, alcohol and other drug use, risky sexual behavior including teen pregnancy, unhealthy dietary behaviors and physical inactivity.
8. To reduce obesity in Indiana.
9. To reduce the rates of domestic violence to women and children, child abuse and childhood injury in Indiana.

ISDH MCSHC proposes to replace the current SP 09 -- SP 15 with new SP 01 -- 08. The proposed new SP will be:

SP 01 The number of data sets, including the NBS, UNHS, Lead, Indiana Birth Defects and Problems Registry, Immunizations, CSHCS, and First Step Data, that are completely integrated into the Indiana Child Health Data Set. (Similar to previous SP 09)
SP 02 The rate per 10,000 for asthma hospitalizations (ICD 9 Codes: 493.0-493.9) among children less than five years old. (Previously SP 10)
SP 03 The percent of live births to mothers who smoke. (Previously SP 11)
SP 04 The percent of black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate. (Previously SP 12)
SP 05 The percentage of children with blood lead levels equal to or greater than 10 Micrograms per deciliter. (Similar to previous SP 14)
SP 06 The proportion of births occurring within 18 months of a previous birth. (New)
SP 07 The number of community/neighborhood partnerships established in 5 targeted counties to identify perinatal disparities so that appropriate responses can be implemented at the local level to lessen these differences. (New)
SP 08 The percentage of high school students who are overweight. (New)

MCSHC proposes to discontinue two current SP:
SP 13 The degree to which the State assures family participation in program and policy activities in the State MCHS program; and
SP 15 To facilitate the integration of genetics and build genetics capacity within other areas of public health.

The identified priority needs will be impacted by activities in the listed Performance Measures as follow:
Priority 1 is addressed in PM 01, PM 08, PM 15, PM 17 & PM 18 and SP 01, SP 03, SP 04, SP 06 & SP 07
Priority 2 is addressed in PM 02, PM 03, PM 04, PM 05, PM 06, PM 07, PM 09, PM 13, PM 14 & PM 19 and SP 04 & SP 07
Priority 3 is addressed in PM 02, PM 03, PM 04, PM 05, PM 06 & PM 11 and SP 04, SP 05, SP 06, SP 07 & SP 08
Priority 4 is addressed in PM 01, PM 12, PM 17 & PM 18 and SP 01, SP 02, SP 03 & SP 05
Priority 5 is addressed in SP 03
Priority 6 is addressed in SP 01
Priority 7 is addressed in PM 08, PM 10 & PM 16
Priority 8 is addressed in SP 08
Priority 9 is addressed in PM 08 & PM 16

MCSHC grants approximately $7.5 million to fund more than 50 local and statewide projects that build infrastructure and provide population-based, enabling and direct services to meet these objectives. Additionally, beginning in FY 2005, MCSHC has provided approximately $1 million in one-time infrastructure grant funds to more than 30 local and statewide projects to conduct community needs assessment, operate pilot projects or otherwise address the priority needs and performance measures above.

Activities of MCSHC staff and grantees to meet these performance measures are discussed in sections C and D below.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			99	99	99
Annual Indicator			99.4	99.6	99.1
Numerator					87148
Denominator					87927
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99.2	99.2	99.3	99.4	99.5

Notes - 2002

Figure provided by ISDH NBS Program Director.

Notes - 2003

Provisional figure calculated from information previously provided by ISDH NBS Program Director.

Notes - 2004

Source: Newborn Screening program.

a. Last Year's Accomplishments

FY 2004 Performance Objective: Maintain or improve at 99% the percent of newborns receiving initial screen and 100% of infants with confirmed positive receiving treatment and follow-up.

OBJECTIVE MET at 99.1%

*Continued to follow-up on all screening results until they were complete and negative or confirmed positive and receiving treatment.
*Continued to ensure referral of children with positive screens to one or more of the following: Metabolic Genetics, Endocrinology, Sickle Cell Centers, First Steps and CSHCS programs.
*The NBS Director continued to participate in the screening subcommittee of the Indiana Genetics Advisory Committee.
*Worked closely with the Public Health Nurses for follow-up as needed.
*Provided 15 in-service trainings to Public Health Nurses and 8 hospitals.
*Completed computerized tracking via Access database

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. The NBS program (NBS) will continue to ensure follow-up services on infants with abnormal or positive newborn screens for metabolic conditions, conginital hypothyroidism and adrenal hyperplasia.		**X**		

2. NBS will continue to monitor the rate of infants screened prior to hospital discharge for Quality Assurance.				X
3. NBS will continue to collect & monitor Meconium screening data & collaborate w/other drug screens.				X
4. NBS will continue to provide training to professionals regarding all newborn screens.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: Increase to 99.2% the percent of newborns who are screened for Indiana mandated conditions and receive appropriate follow-up and referral as defined by Indiana's Newborn Screening Program.

*Begin development of interfacing IU NBS lab data into the Operational Data Store (ODS).
*Continue to follow-up on all screening results until they are complete and negative or confirmed positive and receiving treatment.
*Continue to ensure referral of children with positive screens to one or more of the following: Metabolic Genetics, Endocrinology, Sickle Cell Centers, First Steps and CSHCS programs.
*The NBS Program Director will re-establish the NBS Advisory Committee.
*The NBS Director will continue to participate on the screening subcommittee of the Indiana Genetics Advisory Committee.
*Continue to provide at least 10 in-service training to Public Health Nurses, 15 hospitals, and 1 birthing facility.

c. Plan for the Coming Year

FY 2006 Performance Objective: Maintain or improve at 99.2% the percent of newborns who are screened for Indiana mandated conditions and receive appropriate follow-up and referral as defined by Indiana's Newborn Screening Program.

*Continue the development of the NBS datamart through the Operational Data Store (ODS).
*Continue to follow-up on all screening results until they are complete and negative or confirmed positive and receiving treatment.
*Continue to ensure referral of children with positive screens to one or more of the following: Metabolic Genetics, Endocrinology, Sickle Cell Centers, First Steps and CSHCS programs.
*The NBS Program Director will continue to work with the NBS Advisory Committee.
*The NBS Director will continue to participate on the screening subcommittee of the Indiana Genetics Advisory Committee.
*Continue to provide in-service trainings to Public Health Nurses, hospitals, and birthing facilities.
*Outreach to midwives by providing training to increase their birth reporting and to encourage their promotion of newborn screens to clients.
*Create an annual NBS report.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18*

years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				61.1	63
Annual Indicator			61.1	61.1	61.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	63	63	64	64	64

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

FY 2004 Performance Objective: The percent of children with special health care needs age 0 to 18 whose families partner in decision-making at all levels will be satisfied with the services they receive will increase to 63%.

CURRENT DATA NOT AVAILABLE

*Indiana Parent Information Network (IPIN) and Riley Hospital provided training to new pediatric residents, parents, providers, and others linked to parent-advisory groups using ISDH CSHCS funds.
*IPIN trained families about health care financing in the private insurance sector as well as state-funded systems such as Medicaid and the State's high-risk insurance pool program through a grant from ISDH CSHCS.
*Parents assisted in the preparation and review of the priorities and performance measures found in the ISDH Maternal and Child Health (MCH) Title V Block Grant.
*The MCSHCS Division Director served on the State Transition Team made up of Early Intervention, Head Start, Special Education, and First Step (FS) representatives.
*Indiana Hemophilia and Thrombosis Center (IHTC) provided outreach and direct services for care coordination, referrals, and dental coverage to the Amish Community.
*ISDH/MCSHC funded the Indiana Medical Home Project survey coordinated by Dr. Nancy Swigonski and IPIN to determine parents' and providers' levels of understanding and

satisfaction with the ISDH CSHCS program and its associated policies that link children to primary medical homes. The survey results were finalized last year.
*The CSHCS Program facilitated participation on the Advisory Committee by allowing participation by phone to ease the burden of child care and travel.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCS will continue to provide reimbursement for primary care services provided in a MD's office.	X			
2. CSHCS will continue to provide a Customer Service / Prior Authorization helpline for clients.		X		
3. CSHCS will continue to assess licensure/credential status of CSHCS health care providers.				X
4. CSHCS will continue to ensure parental involvement via contracts with the IPIN.				X
5. CSHCS will continue to train its employees in cultural competency.				X
6. CSHCS will publish brochures and pamphlets in Spanish to promote outreach to Hispanic parents.		X		
7. CSHCS will revise policies based upon survey data obtained from parents of CSHCN.				X
8.				
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: The percent of children with special health care needs age 0 to 18 whose families partner in decision-making at all levels will be satisfied with the services they receive will be 63% from SLAITS data.

*The CSHCS program will renew its contract IPIN to ensure parental involvement and make funding available for prenatal training, newsletters, special projects, etc.
*The CSHCS program will publish Spanish brochures and pamphlets to promote outreach to Hispanic parents. Although it does not have a Spanish-speaking consultant, CSHCS uses the translation services provided through the Indiana Family Helpline when needed.
*CSHCS will continue to update parents/guardians of program policies via the CSHCS Newsletter and web page.

c. Plan for the Coming Year

FY 2006 Objective: The percent of children with special health care needs age 0 to 18 whose families partner in decision-making at all levels will be satisfied with the services they receive will remain at 63% from SLAITS data.

*In addition to brochures, CSHCS had all the programs letters translated into Spanish. Letters will be added to ACAPS system to send to the program's Spanish-speaking participants.
*CSHCS will develop a satisfaction survey for parents/guardians of the program's participants to determine how they feel services can be improved.
*The CSHCS Participants Manual will be reviewed and updated by staff. Every program

participant will be mailed a new copy of the updated manual. CSHCS will also produce a Spanish language version of the Participants Manual.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				55.7	56
Annual Indicator			55.7	55.7	55.7
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	56	56	56	57	57

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

FY 2004 Performance Objective: The percent of CSHCN in Indiana who have a "medical/health" home will be increased to 56% in FY 2004.

CURRENT DATA NOT AVAILABLE

*Through the Genetics Implementation Grant, the Indiana Parent Information Network and Unified Training Services (UTS) continued providing physician training in communities by holding 6 trainings. Two Medical Home advisory meetings were held. This has assisted in developing the infrastructure to promote the medical home concept.
*Practitioners were identified who care for children with special health care needs in the CSHCS program.
*Professional training for newly contracted doctors was provided through a four-part video to physicians and their staff who provide primary care services to CSHCN.
*CSHCS customer services consultants continued to assist CSHCS enrolled clients in linking to a medical home.

*First Steps service coordinators continued to facilitate a medical/health home for all clients enrolled.
*The First Steps NICU outreach referral system for the 0-3 population continued to link/enroll NICU babies/families into First Steps and possibly into CSHCS before discharge and assists families into a medical home as part of the Individualized Family Service Plan (IFSP).
*ISDH continued to pay for all in office primary care provider (PCP) services, specialty care providers (SCP) for services related to eligible diagnosis, most dental services, and all legend drugs at the maximum Medicaid-allowed rates for CSHCS participants.
*84.6% of CSHCS participants were linked to a primary care provider (medical home) as a requirement of enrollment.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCS will continue to implement HIPAA compliant information system to facilitate linkage/tracking of medical svstems.				X
2. CSHCS will continue to implement HIPAA compliant data linkages for CSHCS, Newborn Screening,Sickle Cell & other ISDH programs.				X
3. CSHCS will streamline enrollment process for providers to expand choice of providers for families.				X
4. Genomics Program will continue to support community physician training in Medical Homes through the Genetics Implementation Grant.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: The percent of CSHCN in Indiana who receive coordinated, ongoing, comprehensive care within a "medical/health" home will be maintained at 56% in FY 2005.

*The ACAPS system of data collection and reimbursement for the CSHCS program has been implemented and discussions are being held regarding data linkages. This systems tracks the linkages of clients to primary care providers, specialty care providers, and dental care providers
*Data systems analysis for integration for the Newborn Screening, UNHS, and Sickle Cell programs is currently being completed. The implementation of integration of this data should be complete by the end of 2005. This will assist in tracking primary care providers for clients in these programs.
*Medical Passport for Children with Special Health Care Needs is being updated and will be remarketed.
*Through the Genetics Implementation Grant, the Indiana Parent Information Network and Unified Training Services (UTS) have continued providing physician training in communities by holding 10 trainings. One Medical Home Advisory meeting was held. This continues to assist in developing the infrastructure to promote the medical home concept.

c. Plan for the Coming Year

FY 2006 Performance Objective: The percent of CSHCN in Indiana who have a "medical/health" home will be maintained at 56% in FY 2006.

*The integration of the Newborn Screening, UNHS, and Sickle Cell programs into the ODS will be completed by the end of 2005. This will assist in tracking primary care providers for clients in these programs.
*Medical Passport for Children with Special Health Care Needs will be remarketed.
*Through the Genetics Implementation Grant, the Indiana Parent Information Network and Unified Training Services (UTS) have continued providing physician training in communities by holding 6 trainings. One Advisory meeting will be held. This continues to assist in developing the infrastructure to promote the medical home concept.
*An educational piece for parents regarding Medical Home will be developed or selected and will be included in mailings to consumers from the NBS, CSHCS, and IFHL programs.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				63.3	65
Annual Indicator			63.3	63.3	63.3
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	65	67	67	69	69

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

FY 2004 Performance Objective: Children with special health care needs who have a source of insurance for primary and specialty care will be increased to 65% in FY 2004. The SLAITS survey is done every other year and the related fields are pre-filled on the grant application for

all states.

CURRENT DATA NOT AVAILABLE

*The CSHCS Program used the combined enrollment form to facilitate enrollment in various public insurance programs for children with special health care needs.
*A CSHCS Specific Web Page has been created to provide information to potential applicants to promote outreach. The URL is http://www.in.gov/isdh/programs/cshcs/.
*The CSHCS Program implemented the new Agency Claims and Administrative Processing System (ACAPS). The system was designed to better capture private insurance that the participants are covered under. In addition there is a electronic file match with Indiana Medicaid's eligibility system. For participants that are found to be on both CSHCS and Medicaid, this file match loads information about the participant's Medicaid coverage. All of this information allows program staff to deal more effectively and efficiently with participants and/or their families to access coverage.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement HIPAA compliant information system to track & facilitate updates of insurance enrollment.				X
2. Continue to use a combined enrollment form that facilitates enrollment in Medicaid and First Steps also.				X
3. Develop an online enrollment form for CSHCS.				X
4. Develop/update a CSHCS web page for potential applicants.				X
5. Update current phone system to make more user friendly for parents and providers.				X
6. MCSHC grantees will continue to enroll or refer to enroll uninsured children who are eligible into the Hoosier Healthwise Program.		X		
7. IFHL will continue to screen callers for insurance coverage and refer to Hoosier Healthwise.		X		
8. CSHCS will continue to require applications be made to Hoosier Healthwise as part of the CSHCS application.				X
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: Children with special health care needs who have a source of insurance for primary and specialty care will be maintained at 65% in FY 2005.

*Since implementation of the ACAPS system, the CSHCS program continues to implement changes and improvements within ACAPS to better address the needs of the participants and program.
*Investigate and assess the viability of on-line enrollment forms on a web-based system.
*Bill Medicaid for travel reimbursement to maximize the CSHCS state budget while having no impact upon family services.
*Update and enhance the telephone/communication system that is currently in place to provide additional options to parents and providers.

c. Plan for the Coming Year

FY 2006 Performance Objective: Children with special health care needs who have a source of insurance for primary and specialty care will be maintained at 65% in FY 2006.

*Develop material to distribute to participants that helps them understand the need to utilize and keep their insurance and the need to disclose it whenever services are rendered.
*Update the CSHCS Provider Manual to include more information about requirements to bill all other available insurance before CSHCS is billed. Include language to encourage provider to work with families so they understand how insurance effects the provider of service.
*Continue to develop the ACAPS system so that insurance information can be shared more easily with providers, with families so that it can be kept up to date and within program areas that work directly with providers and participants.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				79.5	80
Annual Indicator			79.5	79.5	79.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	80	80	82	82

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

FY 2004 Performance Objective: 80% of families with children with special health care needs age 0 to 18 will report the community-based services systems are organized so they can use them easily. (Baseline SLAITS data)

CURRENT DATA NOT AVAILABLE

*CSHCS obtained signed HIPAA compliant provider agreements from all participating providers.
*CSHCS hired 14 new Clerical Assistants II staff persons to process claims, to enter new program applications in the system and to annually re-evaluate program participants for continued program eligibility. These positions eliminated the need for temporary staff, provided a more stable workforce and decreased staff turnover. Staff will be replaced as they leave.
*CSHCS updated the program's policies.
*CSHCS implemented HIPAA compliant claims payment CSHCS claims payment and information system that will accept electronic billing from providers to potentially increase the number of participating providers.
*ISDH provided updated Provider Manuals to all CSHCS providers to promote better understanding of CSHCS HIPAA compliant billing procedures.
*The CSHCS program devoted one FTE, Social Service Specialist III position to provide current community based training to First Steps providers and the Division of Family and Children (DFC) providers to facilitate the CSHCS Program's mission to promote systems development to improve the organization and delivery of services to children with special health care needs.
*ISDH awarded $1,450,989 to 15 community based projects for sickle cell education and services, Amish outreach and dental services, spina bifida, congenital adrenal hyperplasia, dietary supplement, and follow-up, congenital hypothyroidism, and inborn errors of metabolism and dietary supplement.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement HIPAA compliant CSHCS claims payment information system that will accept electronic billing.				X
2. Continue to provide community-based training to First Steps providers and DFC staff.				X
3. Publish web-based bulletins and information updates for providers specific to their specialty.				X
4. Obtain signed HIPAA compliant provider agreement from all participating providers.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: 80% of families with CSHCN age 0 to 18 will report the community-based services systems are organized so they can use them easily.

*The CSHCS program will continue to devote one FTE, Social Service Specialist III position to provide current community based training to First Steps providers and the Division of Family and Children (DFC) providers to facilitate the CSHCS Program's mission to promote systems

development to improve the organization and delivery of services to children with special health care needs.
*ISDH funds and collaborates with IPIN and its statewide network of family-to-family peer support. ISDH reimburses families for in-state and out-of-state transportation of participants to medical facilities for services.
*ISDH provides outreach to Neonatal Intensive Care Units (NICU), maintains and provides lists of primary care physicians participating in the CSHCS program, maintains an 800 Family Help Line with V/TDD capabilities and bilingual support, promotes Single Points of Entry (SPOE) early intervention sites, utilizes local Offices of Family and Children to take CSHCS applications, dispatches a central office customer service representative on an "as needed" basis to take applications in specialty care centers, and maintains an information and application site at Riley Hospital.
*IPIN parent liaison services provide peer support and education services to families interacting with schools, hospitals and medical providers. Support and education provides for better navigation of community-based service systems.

c. Plan for the Coming Year

FY 2006 Performance Objective: 80% of families with CSHCN age 0 to 18 will report the community-based services systems are organized so they can use them easily.

*Update program information on the CSHCS website.
*CSHCS refers families to community-based services through the Indiana Family Helpline.
*The CSHCS program will continue to devote one FTE, Social Service Specialist III position to provide current community based training to First Steps providers and the Division of Family and Children (DFC) providers to facilitate the CSHCS Program's mission to promote systems development to improve the organization and delivery of services to children with special health care needs.
*ISDH will continue to fund and collaborate with IPIN and its statewide network of family-to-family peer support. ISDH will continue to reimburse families for in-state and out-of-state transportation of participants to medical facilities for services.
*ISDH will provide outreach to Neonatal Intensive Care Units (NICU), maintain and provide lists of primary care physicians participating in the CSHCS program, maintain an 800 Family Help Line with V/TDD capabilities and bilingual support, promote Single Points of Entry (SPOE) early intervention sites, use local Offices of Family and Children to take CSHCS applications, dispatch a central office customer service representative on an "as needed" basis to take applications in specialty care centers, and maintain an information and application site at Riley Hospital.
*IPIN parent liaison services will continue to provide peer support and education services to families interacting with schools, hospitals and medical providers.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance				5.8	6

Objective					
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	6	8	8	8

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

FY 2004 Performance Objective: 6% of youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life.

CURRENT DATA NOT AVAILABLE

*The CSHCS staff that provides training is also the Program's transition specialist. This staff person will continue to work closely with the IPIN parent liaisons to facilitate the transition of CSHCS participants to all aspects of adult life.
*The CSHCS Program contracts and works collaboratively with Dr. Tim Brie at the Spina Bifida Clinic at Riley Hospital to provide transition assistance services to children with spina bifida.
* CSHCS Web Page includes age specific and appropriate information for parents and participants to access including appropriate links to groups like the Indiana Parent Information Network, ISDH Family Helpline, Hoosier Healthwise , Child Care Answers, Supplemental Security Income (Social Security Disability),Vocational Rehabilitative Services, IN*Source (Parent Information), and the Indiana Comprehensive Health Insurance Association.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide continuous training to CSHCS staff on transition issues.				**X**
2. Publish transition information on the Web site.				**X**
3. Publish newsletter to CSHCS families/participants with listings for community resources & support systems.		**X**		
4. Mail adolescent clients transition educational materials using client database for mailing lists.		**X**		
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: 6% of youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life.

*ISDH has offered a grant to Indiana University for a CSHCN transition to adult care pilot project. This three-year project will include a needs assessment to gather information from Indiana CSHCN, parents and care providers as well as a demonstration project in which a transition team will provide transitional consultation, information and referral and primary care. The transitional services may eventually be funded through ISDH CSHCS. ISDH and IU are currently working out the details of this grant.
*CSHCS Staff assigned to this PM will establish and maintain contact with IPIN and Riley personnel to accomplish goals listed above.
*CSHCS contracts with Dr. Tim Brie at the Spina Bifida Clinic at Riley Hospital to provide transition assistance services to children with spina bifida.

c. Plan for the Coming Year

FY 2006 Performance Objective: 6% of youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life (CSHCN Survey).

*Provide ongoing continued education to the CSHCS staff specialist, who in turn, will provide training and updates to CSHCS staff.
*Reinitiate the publication of a newsletter to CSHCS families and participants with listings for community resources and support systems.
*Utilize the new CSHCS claims/information system to generate mailing lists for adolescents to target specific mailings appropriate to their age categories and potential topics of interest.
*Work with the funded CSHCN transition clinic to develop transition assistance for clients and training for providers.
*Work with any interagency initiatives regarding transition for disabled individuals from school to work or youth to adult health services.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	80	81	82	83	80
Annual Indicator	75.3	80.8	78.5	79.5	78.5

Numerator	183852	204534	201453	203559	
Denominator	244159	253136	256710	256084	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	81	82	83	84	85

Notes - 2002

FY 2001 Source of denominator: US Census Bureau. Source of percentage data: US National Immunization Survey. Figure used is higher of range. Numerator is a calculation derived from denominator and percentage figures.

FY2002 Only US NIS percentage available. Provisional estimate used for denominator. Numerator calculated from provisional denominator and actual US IS percentage.

Notes - 2003

Due to lower figure for last three years consecutively, objectives for 2004 and future were lowered.

Numerator for 2003 calculated from figures provided by ISDH Epidemiology Resource Center.

Source: ISDH ERC

Notes - 2004

2004 data not yet available. Estimate provided based on trend analysis.

a. Last Year's Accomplishments

FY 2004 Performance Objective: The percent of children through age 2 who have completed immunization for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B will be 80% in FY 2004.

NOT MET at 78.5%

*The Indiana State Department of Health (ISDH) Vaccines for Children (VFC) Program continued to supply all Advisory Committee on Immunization Practices (ACIP) recommended vaccines for VFC eligible children as well as all other children seen in MCSHC clinics with PHS 317 funds.
*All MCSHC grantees either provided direct vaccination services or referrals to providers who do. All MCSHC grantees providing enabling services (prenatal and family care coordination) facilitate clients into obtaining appropriate immunizations for children.
*All eleven MCSHC grantees providing immunizations to more than 25 children in the 19 to 35 month old age group received an Operational Program Review, Clinic Assessment Software Application (CASA) and follow-up (AFIX) to determine their immunization rate of this age group.
*All MCSHC grantees that administer childhood immunizations conducted reminder/recall activities to bring children into their facilities to receive appropriate vaccinations.
*The percentage of MCSHC clinics utilizing Child and Hoosiers Immunization Registry Program (CHIRP) was only 36% in 2004.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

	Pyramid Level of

Activities	Service			
	DHC	ES	PBS	IB
1. MCSHC grantees will get VFC and 317 vaccine for children for on site immunizations.				X
2. IFHL will continue to provide education and referrals to callers regarding immunizations.		X		
3. MCHS grantees giving immunizations will receive Clinic Assessment Software App. & follow-up (AFIX).				X
4. MCSHC grantees will use the CHIRP (Immunization Registry).				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: The percent of 19 to 35 month olds who have received full schedule of age appropriate immunization for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B will increase to 81% in 2005.

*All MCSHC sites that deliver immunization services receive both VFC vaccine (for VFC eligible children) and PHS 317 funded vaccine for all other children.
*All MCSHC grantees providing immunizations to more than 25 children in the 19 to 35 month old age group will receive an Operational Program Review this year, Clinic Assessment Software Application (CASA) and follow-up (AFIX) to determine their immunization rate of this age group.
*All MCSHC grantees are being encouraged to conduct reminder/recall activities to bring children into their facilities to receive appropriate vaccinations. Grantees may use the CHIRP (the state-wide immunization registry) reminder/recall capabilities.
*The ISDH Immunization Program is working with MCSHC sites to increase participation in CHIRP to 75% on 2005.
*IFHL continues to provide education and referrals to callers in need of immunization services.

c. Plan for the Coming Year

FY 2006 Performance Objective: The percent of 19 to 35 month olds who have received full schedule of age appropriate immunization for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B will increase to 82% in 2006.

*The ISDH Immunization Program will continue to provide all ACIP recommended vaccine to all MCSHC sites.
*The ISDH Immunization Program will conduct CASA/AFIX and on-site review visits at all MCSHC sites.
*The ISDH Immunization Program will increase MCSHC site enrollment in the CHIRP system to 75%.
*The ISDH Immunization Program will work with MCSHC sites to increase the number of sites using reminder/recall systems to 75%.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	27	26	25	23	22
Annual Indicator	26.6	23.7	22.5	21.5	20.4
Numerator	3357	3032	2931	2817	
Denominator	126124	128140	130141	130897	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	20	19.5	19	18.5	18

Notes - 2002

Data provided is consistant with previous years. Data provided by ISDH ERC. Most recent available data for denominator from FY2001. FY2002 denominator should be available from ERC fall of '03.

Notes - 2003

Source of data: ISDH ERC, US Census Bureau.

Notes - 2004

2004 data not yet available. Estimate provided based on trend analysis. Objective changed to 21, but web program would not allow change.

Source: U.S. Census Bureau, ISDH ERC

a. Last Year's Accomplishments

FY 2004 Performance Objective: The birth rate for teenagers aged 15-17 years will drop to 22 per 1000 in FY 2004.

OBJECTIVE MET at 20.4 per 1000

*The Indiana RESPECT (Reducing Early Sex and Pregnancy by Educating Children and Teens) Initiative continued to grant state adolescent pregnancy prevention education funds and federal sexual abstinence education funds to agencies providing services to elementary, middle, and high school youth and the parents of teens.
*For FY 04-05, 26 federally funded grantees provided programs that stress sexual abstinence until marriage and 29 state-funded grantees are providing adolescent pregnancy prevention programs that stress sexual abstinence throughout the teen years.
*The State Adolescent Health Coordinator (SAHC) initiated the process of implementing a new statewide abstinence and pregnancy prevention media campaign. MZD (Montgomery, Zukerman, and Davis) was selected by RFP.
*The Spanish language outreach media campaign targeting Latino parents (2003) had significant acceptance and success based on the research following the campaign. Therefore,

the campaign was reinstated May-July of 2004. The campaign included the addition of television spots, which were available on a Spanish station in Indianapolis.
*The SAHC worked on the release of the 2003 YRBS results in the spring of 2004. Release activities included a press release, fact sheets, as well as a web-based component (HTTP://WWW.IN.GOV/ISDH/DATAANDSTATS/YRBS/). The official date of release was May 21, 2004.
*The adolescent health care program continued to address the health and psychosocial needs of the 10 to 19-year-old population in school-based health centers and public health clinics. Both clinical settings offer adolescents comprehensive preventive health services including physical exams, diagnosis, treatment and referral for illness or chronic health problems, nutritional assessment and counseling, psychosocial assessment and intervention, and health education. All the adolescent clinics have adopted objectives to reduce adolescent pregnancies, reduce the number of school dropouts, and increase compliance with health care referrals. The MCH Block Grant provides partial funding for 5 school-based clinics serving approximately 4,327 students.
*Indiana Department of Education (IDOE) received CDC funds for a Coordinated School Health program. ISDH received funding from IDOE to hire a Project Director to begin intra-agency and interagency collaboration among other activities. The expected outcome of this effort is to help schools reduce priority health risks among youth, especially those risks that contribute to chronic diseases.

See Attachment

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCSHC will continue Indiana RESPECT Sexual Abstinence Education and Adolescent Pregnancy Prevention Initiative with federal & state funds.				X
2. MCSHC will continue funding local entities for abstinence education services.		X		
3. Indiana RESPECT media campaign will be continued.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: The birth rate for teenagers aged 15-17 years will drop to 20 per 1000 in FY 2005.

*The Administration of Children and Families (ACF) Federal Abstinence Education Grant Program: The SAHC developed and submitted the FY' 05 Federal Abstinence Education Grant, which, in combination with State adolescent pregnancy prevention education funding, is used to fund the Indiana RESPECT Adolescent Pregnancy Prevention Initiative. Twenty six local grantees were selected for state funding. Selection for local grantees to receive federal Section

510 funds is ongoing.
*The SAHC provided technical assistance to all federal and state grantees and to interested youth-serving agencies across the state regarding topics such as grant selection, adolescent programming, and the YRBS.
* SAHC and MZD, Inc. are developing a new sexual abstinence media campaign that will target all of Indiana's parents and teens. Focus groups and telephone surveys are currently being administered, creative development will take place in the summer and the public release will follow in the fall. The new campaign materials will include parent and teen brochures, billboards, posters, radio and television and movie theatre advertisements and an interactive website.
*Once the new media campaign is released to the public, the SAHC will work closely with MZD to disseminate all new media materials to youth-serving agencies across the state and to ensure that the public is made aware of the availability of the free media materials.
*The 2005 YRBS was administered across the state from January to May 2005. State results from the 2005 YRBS should be available by the fall of 2005.
*The adolescent health care program continues to address the health and psychosocial needs of the 10 to 19-year-old population in school-based health centers and public health clinics.
*All MCHSC funded school based health centers continue to provide either prenatal care coordination on-site or refer for prenatal care coordination any pregnant student.
*MCHSC continues to ensure that the Free Pregnancy Test Program agencies provide counseling/referrals to health care providers or provide abstinence or family planning information to sexually active teens with negative pregnancy tests.
*SAHC worked to heighten awareness of the National Day to Prevent Teen Pregnancy for May 2005.
*SAHC will continue developing a proposed statewide adolescent health coalition. Some of the main goals for the coalition might be dissemination of the 2005 YRBS results and beginning work on a state adolescent health plan.
*ISDH and a physician with the Indiana University School of Medicine will continue developing an evaluation component of RESPECT programs across the state.
*As a requirement of the ACF Federal Abstinence Education Grant Program, the SACH will now provide Youth Development technical assistance seminars to interested youth-serving agencies around the state.
See Attachment

c. Plan for the Coming Year

FY 2006 Performance Objective: The birth rate for teenagers aged 15-17 years will drop to 19.5 in FY 2006.

*ACF Federal Abstinence Education Grant Program: The SAHC will develop and submit the FY' 06 Federal Abstinence Education Grant.
*SAHC will provide technical assistance to all local RESPECT grantees and to interested youth-serving agencies across the state regarding topics such as grant writing, adolescent programming, YRBS, and Youth Development.
*SAHC will continue to monitor the progress and effectiveness of the Abstinence Education Media Campaign.
*SAHC will play in integral part in the spring 2006 release of the National Comparison 2005 YRBS data.
*The adolescent health care program will continue to address the health and psychosocial needs of the 10 to 19-year-old population in school-based health centers and public health clinics.
*All MCHSC funded school based health centers will continue to provide either prenatal care coordination on-site or refer for prenatal care coordination any pregnant student.
*MCHSC will continue to ensure the Free Pregnancy Test Program agencies provide counseling/referrals to health care providers or provide abstinence or family planning

information to sexually active teens with negative pregnancy tests. The Program will continue to be offered at all funded school based health centers and MCSHC clinics.
*In the spring of 2006, the SAHC will once again highlight the National Day to Prevent Teen Pregnancy and brochures will be distributed across the state.
*SAHC will work with an Adolescent Health Coalition or advisory group to develop a State Adolescent Health Plan.
*The SAHC will continue to collaborate with the ISDH Community Nutrition/Obesity Prevention Division to combat adolescent obesity.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	30	30	33	35	42.7
Annual Indicator	33.5	34.7	41.2	47.3	45.1
Numerator	29519	28448			
Denominator	88116	81984			
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	46	47	48	49	50

Notes - 2002

Source of Percentage for 2002: ISDH Oral Health program.

Note: In the past, multiple methods have been used to find this measure, including questions on the BRFSS and in-mouth surveys. Questionnaire surveys from 2000 and 2001 and in-mouth survey from Fall 2000 were conducted. Using these three surveys, an estimate of this measure has been calculated for the 2001 figure. If the questionnaire survey is continued, data from the questionnaire will be used for future reports. Otherwise, projections based on previous information obtained will be used to calculate this measure.

Notes - 2003

Source of Percentage for 2003: ISDH Oral Health program.

Note: In the past, multiple methods have been used to find this measure, including questions on the BRFSS and in-mouth surveys. Questionnaire surveys from 2000 and 2001 and in-mouth survey from Fall 2000 were conducted. Using these three surveys, an estimate of this measure has been calculated for the 2001 figure. If the questionnaire survey is continued, data from the questionnaire will be used for future reports. Otherwise, projections based on previous information obtained will be used to calculate this measure.

Notes - 2004

Note: In the past, multiple methods have been used to find this measure, including questions on the BRFSS and in-mouth surveys. Questionnaire surveys from 2000 and 2001 and in-mouth survey from Fall 2000 were conducted. Using these three surveys, an estimate of this measure has been calculated for the 2001 figure. If the questionnaire survey is continued, data from the questionnaire will be used for future reports.

2004: The questionnairre was continued.

Source of Percentage for 2003-2004: ISDH Oral Health program.

a. Last Year's Accomplishments

FY 2004 Performance Objective: The percent of third grade children who have received protective sealants on at least one permanent molar tooth will increase to 42.7% in FY 2004.

OBJECTIVE MET at 45.1%

*In May 2004, the Indiana State Department of Health's Oral Health Division received a Quality Achievement Award at the National Oral Health Convention in Los Angeles, California from the Centers for Disease Control and Prevention. The award, presented to only two other states, was in recognition of Indiana's high rate of maintaining optimal fluoridation in its water systems. Indiana currently has more than 260 water systems that fluoridate. Indiana was also recognized for having at least 50 years of fluoridation programs. Indiana began its program in 1950 in Ft. Wayne.
*A survey of school nurses was done to determine their perception of sealant usages. *ISDH Oral Health Services (OHS) promoted the community and school-based dental sealant program.
*ISDH OHS encouraged Indiana dental providers to participate in Hoosier Healthwise and utilize sealants with those clients to help eliminate disparity in preventive services.
*ISDH OHS promoted the use of pit and fissure sealants to dental/dental hygiene students at I.U. School of Dentistry and to current practitioners throughout the state.
*Since Seal Indiana, (a collaborative effort between the Indiana University School of Dentistry and the Indiana State Department of Health) began in March 2003, over 10,000 dental sealants have been placed in children attending Title I and Head Start schools.
MCSHC funded the Amish Dental Intervention Project which:
*Continued to provide dental care to the medically underserved and uninsured population of Amish children in northern Indiana.
*Continued to provide water testing, education, and fluoride supplements to the medically underserved and uninsured population of Amish children in northern Indiana.
*Continued to provide dental education in the Community Dental Clinic and in the schools.
*Continued to employ services of a full-time dentist.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Oral Health Division & MCSHC continue to support the SEAL Indiana Mobile Unit that provides sealants at schools & CHCs.				X
2. SEAL Indiana & OHD staff will continue to provide technical assistance to local dentists.	X			
3. SEAL Indiana staff will work to establish dental case managers in local communities to assist parents.				X

4. Parent Survey of selected third grade classes in selected schools will continue to monitor sealant usage.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: The percent of third grade children who have received protective sealants on at least one permanent molar tooth will increase to 46% in FY 2005.

*A survey in selected third grades in selected schools, throughout the state, is underway. This will indicate the percentage of sealants based on parent/caregiver reporting.
*Oral Health Services (OHS) continues to promote community-based dental sealant programs, as well as collaborating with the IU School of Dentistry Community Dentistry's sealant placement program. The ISDH Director of Oral Health Services continues to serve on the Board and planning committee of the IU School of Dentistry Mobil Dental Sealant Program.
*ISDH OHS continues to encourage dental providers to participate in Hoosier Healthwise and utilize sealants with Hoosier Healthwise clients to help eliminate disparity in preventive services rendered.
*OHS dentists liaisons with Office of Medicaid and Policy Planning (OMPP) on oral health issues.
*OHS promotes the utilization of pit and fissure sealant to dental/dental hygiene students at IU School of Dentistry and to current practitioners throughout the state.
*OHS provides oral health brochures for distribution to MCSHC, WIC, Head Start, Early Head Start, Baby First Packets, etc., in both English and Spanish. Newly translated to Spanish is brochure on Baby Bottle Tooth Decay (BBTD).
*OHS assists communities to be designated Dental HPSA and collaborates with ISDH Local Liaison office and Indiana Primary Health Care Association.
*OHS collaborates with the Indiana Rural Health Association and the Indiana Primary Health Care Association to provide technical assistance to establish dental services within existing and future CHCs.
*OHS provides sealant educational information to accompany Hoosier Healthwise enrollment information.
*OHS is researching resources for dental case managers in each community. The case manager enrolls low-income children in Hoosier Healthwise and help parents/guardians to find a local source of dental services. These activities assure that each child will have a dental home.
*ISDH MCSHC funds the IU Dental Sealant program to develop strategies to acquire parental consent for school-based oral health services.
*MCSHC continues funding the Amish Dental Intervention Project.

c. Plan for the Coming Year

FY 2006 Performance Objective: The percent of third grade children who have received protective sealants on at least one permanent molar tooth will increase to 47% in FY 2006.

*A survey in selected third grades in selected schools, throughout the state, will be completed. This will indicate the percentage of sealants based on parent/caregiver reporting.
*Oral Health Services (OHS) will continue promoting community-based dental sealant programs, as well as collaborating with the IU School of Dentistry Community Dentistry's

sealant placement program. The ISDH Director of Oral Health Services will continue to serve on the Board and planning committee of the IU School of Dentistry Mobil Dental Sealant Program.
*OHS will continue to encourage dental providers to participate in Hoosier Healthwise and utilize sealants with Hoosier Healthwise clients to help eliminate disparity in preventive services rendered.
*OHS dentists will maintain liaison with Office of Medicaid and Policy Planning (OMPP) on oral health issues.
*OHS will continue to promote the utilization of pit and fissure sealant to dental/dental hygiene students at IU School of Dentistry and to current practitioners throughout the state.
*OHS will provide oral health brochures for distribution to MCSHC, WIC, Head Start, Early Head Start, Baby First Packets, etc., in both English and Spanish. Newly translated to Spanish is brochure on Baby Bottle Tooth Decay (BBTD).
*OHS will assist communities in gaining designation as Dental HPSA. Collaborating with ISDH Local Liaison office and Indiana Primary Health Care Association.
*OHS will collaborate with the Indiana Rural Health Association and the Indiana Primary Health Care Association to provide technical assistance to establish dental services within existing and future CHCs.
*OHS will provide sealant educational information to accompany Hoosier Healthwise enrollment information.
*OHS will work toward finding resources for dental case managers in each community. The case manager will work on enrolling low-income children in Hoosier Healthwise and help parents/guardians to find a local source of dental services. These activities assure that each child will have a dental home.
*ISDH MCSHC projects funding IU Dental Sealant program to develop strategies to acquire parental consent for school-based oral health services.
*The MCSHC funded Amish Dental Intervention Project will continue.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	5.3	5.2	5.1	4	3
Annual Indicator	3.7	3.4	3.4	3.2	3.2
Numerator	47	48	45	43	
Denominator	1276963	1394421	1328071	1325771	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3	3	3	2.5	2.5

Notes - 2002

Source of data: ISDH Epidemiology Resource Center.

No provisional data available yet for FY 2002 from ERC. No reliable estimate possible due to extremely small numbers for numerator.

Notes - 2003

Source of data: ISDH Epidemiology Resource Center.

No provisional data available yet for FY 2003 from ERC. No reliable estimate possible due to extremely small numbers for numerator.

Notes - 2004

2004 data not yet available. Estimate provided based on trend analysis.

a. Last Year's Accomplishments

FY 2004 Performance Objective: The rate of death to children aged 0-14 caused by motor vehicle crashes per 100,000 children will decrease to 3.0 in FY 2004.

NOT MET at 3.2 per 100,000

* MCSHC projects provided education on safety and injury prevention issues, including the use of automobile safety seats and booster seats.
*Communication of new developments related to childhood automotive safety to MCSHC projects.
*CDC's National Center for Injury Prevention and Control (NCIPC) provides ISDH with grant funding for injury prevention efforts (2002-2005). An Injury Epidemiologist is completing an epidemiological analysis of the 2002 hospital discharge database related to injuries.
*The ISDH Injury Prevention Advisory Council meets on a quarterly basis. MCSHC staff participate.
*The Injury Prevention Program is a collaborator in the Crash Outcome Data Evaluation System (CODES), a new National Highway Traffic Safety Administration project for Indiana.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Injury Prevention Program staff will complete reports on injury data needs assessment.				X
2. Program will continue to promote expanded electronic coding by hospitals for all injury-related discharges.				X
3. ISDH will develop a pilot injury surveillance system.				X
4. Injury Prevention Advisory Council will meet quarterly.				X
5. ISDH continues collaboration with the State Emergency Management Agency & Purdue University on Crash Outcome Data Evaluation System.				X
6. Injury Prevention Program staff will complete an injury prevention resource directory.				X
7. Injury Prevention Program staff will develop injury prevention state plan.				X
8.				
9.				

10.					

b. Current Activities

FY 2005 Performance Objective: The rate of death to children aged 0-14 caused by motor vehicle crashes per 100,000 children will be 3.0 in 2005.

*State legislature passed a law requiring the use of booster seats for children up to 80 pounds or 8 years old effective July 1, 2005.
* Detailed statistical report on Injury in Indiana will be published in June 2005. Hospital discharge and mortality data will be included.
*Continue working with the Indiana Automotive Safety Program for Children as well as the Safe Kids Program to promote automotive safety
*Maintain linkage with safety and injury prevention groups in Indiana and nationally.
*Communication of new developments related to childhood automotive safety to MCSHC projects
*The Injury Prevention Program staff has completed an injury data needs assessment and developed a draft of an Injury Prevention State Plan.
*The staff will continue to promote expanded E coding by hospitals for all injury-related discharges.
*The Injury Prevention Advisory Council continues to meet quarterly. ISDH will continue its involvement in the CODES project.
*MCSHC funds Riley Hospital for Children to adapt and implement the "Checkpoints" teen driving program developed by Bruce Simons-Morton of the National Institute of Child Health and Human Development to promote parental involvement in teen driver training.

c. Plan for the Coming Year

FY 2006 Performance Objective: The rate of death to children aged 0-14 caused by motor vehicle crashes per 100,000 children will be 3.0 in 2006.
*Convert draft State Injury Prevention and Control Plan into a final document and begin implementation efforts. Of the five injury problems addressed in the Plan, one objective is to reduce the number of deaths in teens secondary to motor vehicle crashes by X% (to be determined).
*Implement a web-based Injury Prevention Resource Center, a clearinghouse for information and resources for Indiana.
*Injury Prevention Advisory Council will meet quarterly & help ISDH carry out the State Plan.
*Continue working with the Indiana Automotive Safety Program for Children as well as the Safe Kids Program to promote automotive safety
*Maintain linkage with safety and injury prevention groups in Indiana and nationally
*Continue to fund Riley Hospital for Children to adapt and implement the "Checkpoints" teen driving program developed by Bruce Simons-Morton of the National Institute of Child Health and Human Development to promote parental involvement in teen driver training.
*Communicate new developments related to childhood automotive safety to MCSHC projects.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective	60	61	62	63	66
Annual Indicator	59.8	62.6	64.9	63.9	63.2
Numerator	52554	52644	54484	52936	
Denominator	87948	84076	83950	82822	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	66	67	68	69	70

Notes - 2002

Source of data: ISDH Epidemiology Resource Center. Most recent available data for FY2001. FY2002 figures estimated based on multi-year trend.

Notes - 2003

Source of Data: ISDH Epidemiology Resource Center.

Notes - 2004

Provisional data.

Source: ISDH ERC

a. Last Year's Accomplishments

FY 2004 Performance Objective: The percentage of mothers who breastfeed their infants at hospital discharge will increase to 66% in FY 2004.

NOT MET at 63.2%

*WIC contracted with Best Start Social Marketing to conduct regional strategic planning meetings toward developing the State Breastfeeding Strategic Plan. Meetings were ongoing in 2004. Data from these meetings will be used to develop the State Breastfeeding Strategic plan.
*The Indiana WIC program requested and received $849,935, using FY 2003 WIC food funds from USDA/FNS, to purchase and rent electric and manual breast pumps for WIC breastfeeding mothers. The pumps were delivered to local WIC agencies in second six months of 2003 for distribution to WIC participants during 2003 and 2004. This grant addresses a much-requested need especially by working mothers and those with mother-infant separation issues.
*Nationally WIC is promoting establishment or enhancement of peer counselor programs. Indiana WIC has had a successful program for over ten years. Plans to expand this program were made.
*WIC increased funding for breastfeeding programs. Preliminary WIC breastfeeding rates are currently 51.9%. Electric and manual pumps were purchased for a loan program. in addition, WIC gave a one-time supply of pumps to IPN for their breastfeeding campaign to be given to families with severe problems such a premature or sick infants.
*WIC established contracts and procedures for electric breast pumps for loan; all agencies received training on how to use electric pumps.
*WIC co-sponsored a Bright Futures Conference in 2004 with Riley Hospital, the major children's hospital in Indiana, and sponsored a speaker on breastfeeding the preemie both in the hospital and after discharge.
*WIC and the ISDH Office of Minority Health initiated a Fathers Support Breastfeeding

Campaign.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Establishing activities of Regional Support Centers, Peer Counselors, and IBCLC Progams will continue.				X
2. WIC and Indiana Perinatal Network Breastfeeding Committees will continue meeting.				X
3. MCSHC, IPN and WIC will co-publish a breastfeeding strategic plan for the State.				X
4. WIC plans the implementation of Fathers Supporting breastfeeding Campaign.			X	
5. MCSHC Prenatal & Prenatal Care Coordination will continue to encourage breastfeeding to all of their patients.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: The percentage of mothers who breastfeed their infants at hospital discharge will increase to 66% in FY 2005.

In addition to now established activities including the Regional Support Centers, Peer Counselor Program, International Board Certified Lactation Consultants programs, regular meetings of the WIC/IPN Breastfeeding Committee, educational offerings to increase competency among health providers and public health staff, and World Breastfeeding Week activities, the following activities have been initiated:
*Training of new peer counselors was offered during March 2005 to expand the Peer Counselor Program. Contract signed Jan 2005 with Tippecanoe County WIC to hire 4 peer counselors to serve in four to six rural counties. Counties to be served include Boone, Fountain, Hendricks, Parke, and White.
*WIC and IPN Breastfeeding Committee are working together to complete the State Breastfeeding Strategic Plan that will incorporate recommendations made Best Start during the regional strategy meetings.
*The State Breastfeeding Strategic Plan will be published and distributed widely in FY 2005.
*WIC and Office of Minority Health will collaborate to host four (4) "Grandmother Teas" in high-risk counties to raise awareness of the importance of breastfeeding. This project is currently on hold until a new Program Coordinator for the Office of Minority Health is hired.
*MCSHC funded prenatal clinics and Prenatal Care Coordinators are required to encourage breastfeeding to all of their patients and improve breastfeeding rates among their clientele. Funded projects report success in their annual report.
*WIC and the Office of Minority Health provided education to health care providers about the relationship between breastfeeding and infant mortality rates among African Americans during a "Sharing the Vision" conference held for 125 attendees scheduled for November 2005.
*WIC has contracted with Best Start Social Marketing to provide three (3) trainings on worksite breastfeeding promotion, including minority daycare centers in August 2005.

*MCSHC supports activities of the IPN Breastfeeding Subcommittee.

c. Plan for the Coming Year

FY 2006 Performance Objective: The percentage of mothers who breastfeed their infants at hospital discharge will increase to 67% in FY 2006.

*The State Breastfeeding Strategic Plan will be published and distributed widely in FY 2006.
*WIC will expand trainings to professionals through trainings at six (6) to twelve (12) hospitals on management of breastfeeding in the first 2-3 days of life.
*WIC, IPN, and the Breastfeeding Committee will initiate a statewide breastfeeding media campaign.
*Staff on the Indiana Family Helpline (IFHL) will be educated on how to answer and refer questions about breastfeeding prior to the release of the media campaign.
*MCSHC funded prenatal clinics and prenatal care coordinators will continue to be required to encourage breastfeeding to all of their patients and improve breastfeeding rates among their clientele.
*MCSHC will provide training to funded prenatal services projects on best practices for encouraging women to breastfeed.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	75	95	99	99	99
Annual Indicator	83.9	97.0	98.0	99.7	98.3
Numerator	73788	85310	85374	84490	86475
Denominator	87948	87948	87116	84744	87927
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98.4	98.5	98.6	98.7	98.8

Notes - 2002

Source of Percentage for 2002: ISDH Newborn Screening Program.

For previous years: Source of Denominator: Indiana Birth Records, ISDH Epidemiology Resource Center. These totals are for the calendar year and not the fiscal year. Source of Numerator: Indiana Newborn Screening Program.

Notes - 2003

These totals are for the calendar year and not the fiscal year.

Source of Percentage for 2003: ISDH Newborn Screening Program (provisional).

Notes - 2004

Source of percentage: Newborn Screening program

a. Last Year's Accomplishments

FY 2004 Performance Objective: Maintain or improve universal newborn hearing screens at 99% in FY 2004.

NOT MET at 98.3%

*Provided 8 in-services to hospitals and 15 Public Health Nurses trainings. Focused training on correct screening and referral procedures. A specific emphasis was placed on referral of infants based on risk factors.
*Utilized area Regional Audiologist Consultants to assist with in-services and work with UNHS hospital contacts.
*Contracted with a statewide Audiology Consultant to be in house to monitor all babies who need referral, further diagnostics, and early intervention through the CDC Early Hearing Detection Information (EHDI) grant.
*Continued statistics tracking via monthly summary reports and implemented entry of patient centric data into UNHS database to enable timely tracking and follow-up.
*Continued discussion on methods to incorporate UNHS data into the Operational Data Store (ODS), an integrated statewide data management system.
*Designed and implemented automatic letter generation for babies not receiving UNHS, those who did not pass UNHS, and those classified as at risk for delayed onset of hearing loss.
*Collaborated with Indiana University (IU) lab to develop procedures that include UNHS data on blood spot cards.
*ISDH Children's Medical Director and several regional audiologist consultants attended the Early Hearing Detection Information Conference held in February 2004.
*Continued to support the Family Focus Group in conjunction with the Outreach Department at the Indiana School for the Deaf.
*Co-sponsored, with the Outreach Department at Indiana School for the Deaf and the Parent Focus Group, a Family Conference at the Indiana School for the Deaf. 25 families attended the three day conference.
*Began reformation of the UNHS Advisory Board into the EHDI Advisory Committee.
*Implemented the Diagnostic Audiology Evaluation (DAE) form to be completed by audiologists following diagnostic testing
*Participated in a group interested in formalizing the Family Focus Group, a subcommittee of the UNHS Advisory Board, into a not for profit, parent led, parent support and education organization called Hands & Voices.
*Began organizing training for 25 individuals to provide comprehensive, unbiased information to families with deaf or hard of hearing children using the SKI*HI Parent Advisors Curriculum.
*Participated in the Deaf and Hard of Hearing Early Intervention Advisory Committee (DHHEIAC) to discuss professional concerns regarding EHDI screen, follow-up, and intervention procedures within the state of Indiana.

See Attached

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. NBS will continue to ensure that 99% of babies born in Indiana are screened for hearing loss.				X
2. UNHS data will be provided with metabolic screening data via the NBS lab and will be a part of the ODS.		X		
3. NBS will develop a new tracking & follow-up data system to include diagnostic information follow-up.				X
4. The Regional Outreach Program, a 3-year grant, will continue.			X	
5. Family Conference for families of infants with hearing loss will be co-sponsored by Newborn Screening, the School for the Deaf, and the Family Focus Advisory group.			X	
6. The State Early Hearing Detection and Intervention advisory group will meet quarterly.				X
7.				
8.				
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: Increase universal newborn hearing screens to 98.4% in FY 2005.

*Provide at least 10 in-services to hospitals and at least 8 Public Health Nurses trainings.
*Provide technical assistance to hospitals related to newborn hearing screening rules, protocols and reporting requirements through audiologist consultation.
*Track the newborn hearing screen statistics assisted by data obtained from Indiana University (IU) Lab, First Steps, and following letters to families, physicians and public health nurses.
*IU lab has developed and has begun implementing the use of the new bloodspot cards that include UNHS data.
*IU lab's new data management system that will incorporate UNHS data from blood spot cards is planned to be functional during the summer of 2005.
*Continue to provide follow-up on all babies not receiving Universal Newborn Hearing Screening (UNHS), babies not passing UNHS, and babies identified as at risk for delayed onset of hearing loss.
*Maintain newborn screening web site containing most up-dated data regarding the UNHS Program.
*The State Audiologist continues serving on the Board of Directors for the newly formed Indiana Chapter of Hands and Voices.
*Co-sponsor a Family Conference with the Indiana School for the Deaf Outreach Office and the Indiana Chapter of Hands and Voices with funds from the HRSA UNHS grant.
*Provide education on UNHS procedures and promote participation of mid-wives in UNHS procedures.
*A one-year, no cost extension was awarded by the Human Resources and Services Administration to enable continued funding of the Regional Audiology Consultants until March 31, 2006.
*Consult with the Indiana Birth Defects and Problems Registry (IBDPR) to discuss possibility of adding hearing loss as a reported condition.
*The State Audiologist participates in the Indiana Genomics Advisory Committee.
*The State Audiologist attended the Annual EHDI Conference in Altanta, Georgia.
*Begin presenting or exhibiting at 4 -- 5 statewide conferences that provide continuing education to professionals working with deaf and hard of hearing children and their families.
*Updated UNHS brochures and had them translated into Spanish; print these brochures by September 2005.

*Update Family Resource Guide and have it translated in Spanish. Hands and Voices to participate in revision of document to improve family understanding and use of the document.
*Develop contacts in the large Amish communities in northeastern and southwestern parts of Indiana to provide education regarding UNHS/EHDI.
*The State Audiologist collaborated with the state coordinator for the Delta Zeta's Sound Beginnings Program that promotes UNHS across the country.
*Evaluate available UNHS software to determine systems that may be integrated into the ODS and reduce the time and cost of ISDH developing this portion of the ODS.

See Attachment

c. Plan for the Coming Year

FY 2006 Performance Objective: Increase universal newborn hearing screens to 98.5% in FY 2006.

*Continue to provide education and technical assistance to hospitals and birth facilities via the Regional Audiology Consultants.
*Integrate UNHS data from new blood spot card into the Operational Data Store (ODS).
*Develop a plan and begin work on a UNHS/EHDI datamart as part of the ODS which will replace the current Access database.
*Discuss plans for automatic notification of babies not screened, those not passing, and those at risk for delayed onset of hearing loss based on data in the ODS.
*The NBS Director will meet monthly with the ISDH Data Integration Steering Committee (DISC) to improve communication among Information Technology (IT) staff and to minimize barriers to data integration.
*Explore the development web-based Monthly Summary Report (MSR) and Diagnostic Audiology Evaluation (DAE) form reporting.
*Continue to provide educational presentations to students, physicians, families about UNHS/EHDI procedures, goals and objectives.
*Disseminate Medical Home materials specific to UNHS/EHDI to physicians around the state.
*Continue to provide education and support to babies born by mid-wives or at home to ensure UNHS.
*Set up procedures to ensure that children referred from UNHS receive diagnostic audiology services before three months of age.
*Train hospital personnel, audiologists, and otolaryngologists to have families sign the reciprocal release of information to enable sharing of information between First Steps and Newborn Screening Program.
*Continue identifying funding for 5 audiologists to attend NCHAM audiologic assessment training course.
*Continue to exhibit or present at statewide conferences discussing the importance of UNHS and follow-up procedures.
*Discuss collaboration with the AAP Chapter Champion to establish presentations for pediatricians to discuss UNHS/EHDI issues.
*Continue to collaborate with Delta Zeta Sorority to ensure continued dissemination of Sound Beginnings materials to physicians, birthing centers, WIC clinics, and other appropriate entities around the state.
*Continue to ensure that each child identified with hearing loss has a Medical Home.
*Provide follow-up and tracking for home births.
*Continue to emphasize the importance of audiologist reporting via the DAE form for children referred from UNHS or those who did not receive UNHS.
*Continue to provide consultative services to professionals and families regarding diagnostic test result interpretation.
*Set up procedures to track and ensure that children with hearing loss are enrolled in appropriate early intervention services by six months of age.

*Obtain monthly data from First Steps that will fulfill the CDC-EHDI data recommendations that will assist with follow-up, tracking, and available information related to early intervention service delivery.

See Attachment

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	11.5	11	10.5	10	6
Annual Indicator	7.8	7.8	9.0	12.9	12.5
Numerator	119919	121360	142000	206111	
Denominator	1537423	1555907	1574390	1603970	
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	12	11.5	11	10.5	10

Notes - 2002

For FY2001 and forward, source of data is IOMPP and Census Bureau Data, Current Population Survey. A three year average is used because of the large variability of this item from year to year. The numerator is a calculated value.

Beginning FY2003, OMPP has more accurate data reporting capability. Numerator is still calculated from figures provided by Medicaid. Prior years were likely under reported by Medicaid.

Source of data: Medicaid, Census Bureau.

Notes - 2003

For FY2001 and forward, Source of data is IOMPP and Census Bureau Data, Current Population Survey. A three year average is used because of the large variability of this item from year to year. The numerator is a calculated value.

Notes - 2004

For FY2001 and forward, Source of data is IOMPP and Census Bureau Data, Current Population Survey. A three year average is used because of the large variability of this item from year to year. The numerator is a calculated value.

2004 data not yet available. Estimate provided based on trend analysis.

Application would not allow change of FY2004 objective.

a. Last Year's Accomplishments

FY 2004 Performance Objective: To decrease the percent of children without insurance to 6% in FY 2004.

NOT MET at 12.5%

Please refer to NPM # 14 Activities section for this information.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCSHC grantees will continue to serve as or refer clients to enrollment sites for Hoosier Healthwise.		X		
2. Indiana Family Helpline will continue to provide referrals and screen clients for Hoosier Healthwise.			X	
3. MCSHC grantees providing primary care to children will continue to be Medicaid providers.		X		
4. Family Care Coordination grantees will facilitate children into Hoosier Healthwise.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: To decrease the percent of children without insurance to 12% in FY 2005.

Please refer to NPM # 14 Activities section for this information.

c. Plan for the Coming Year

FY 2006 Performance Objective: To decrease the percent of children without insurance to 11.5% in FY 2006.

Please refer to NPM # 14 Activities section for this information.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual					

Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	80	74	83	84	85
Annual Indicator	82.3	82.3	82.3	86.0	85.0
Numerator	369144	407780	404455	422501	417252
Denominator	448511	495480	491440	491218	490996
Is the Data Provisional or Final?				Final	Provisional
	2005	2006	2007	2008	2009
Annual Performance Objective	86	86	86.5	86.5	86.5

Notes - 2002

Source of data: Indiana Office of Medicaid Policy and Planning.

Notes - 2003

In FY2003 the Indiana Office of Medicaid Policy and Planning improved their data reporting capabilities via a new computer system, increasing accuracy of their data and estimates. Percentage provided for 2003 during transition period between computer systems.

Source of data: IOMPP

Notes - 2004

In FY2003 the Indiana Office of Medicaid Policy and Planning improved their data reporting capabilities via a new computer system, increasing accuracy of their data and estimates. Percentage provided for 2003 during transitional period. Numerator available for 2004. Denominator for FY2004 provided by Medicaid as an estimate of number who meet eligibility requirements as of end of FY2004.

Source of data: IOMPP

a. Last Year's Accomplishments

FY 2004 Performance Objective: To increase the percent of Medicaid-eligible children who have received a service paid by the Medicaid program to 85% in 2004.

OBJECTIVE MET at 85%

The activities listed for FY 2004 are ongoing activities. Grantees either enroll or refer clients to Hoosier Healthwise. The Indiana Family Helpline evaluates clients for eligibility and refers if appropriate to Hoosier Healthwise. Indiana is participating in "Covering Kids and Families", a national initiative to reduce the number of uninsured children and adults who are eligible but not enrolled in public health care coverage programs, with Health and Hospital Corporation of Marion County being the lead agency. The projects for this initiative are located in Cass, Fulton, Lake, St. Joseph, Delaware, Allen, Marion, and the seven counties surrounding Marion County. Additionally, some hospitals in Indiana have systems in place to provide health care services to the indigent, poor, underserved and underinsured population. One such system exists in Indianapolis at the Wishard Hospital; the program is known as "Wishard Advantage". Most of the MCSHC grantees providing child health services serve as Medicaid providers for those in need who are eligible for services.

*The MCHB funded project, the Indiana Early Childhood Comprehensive System Program includes the Access to Health Insurance and Medical Homes subcommittee of parents, pediatricians, public health program staff and others who are providing information to the Core Partner Steering Committee regarding existing needs assessments and other pertinent information.
*One of the measurable outcome objectives of the Indiana Child Care Health Consultant Program is to improve access to health insurance, a medical home and preventive health care.
*MCSHC grantees served as either enrollment sites for Hoosier Healthwise or referred clients to local Hoosier Healthwise enrollment sites.
*The Indiana Family Helpline provided referrals and screened clients for Hoosier Healthwise eligibility.
*MCSHC grantees providing primary care to children served as Medicaid providers.
*Family Care Coordination grantees facilitated children into Hoosier Healthwise.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCSHC grantees will continue to serve as or refer clients to enrollment sites for Hoosier Healthwise.		X		
2. Indiana Family Helpline will continue to provide referrals and screen clients for Hoosier Healthwise.			X	
3. MCSHC grantees providing primary care to children will continue to be Medicaid providers.		X		
4. Family Care Coordination grantees will facilitate children into Hoosier Healthwise.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: To increase the percent of Medicaid-eligible children who have received a service paid by the Medicaid program to 86% in 2005.

*The MCHB funded project, the Indiana Early Childhood Comprehensive System Program includes the Access to Health Insurance and Medical Homes subcommittee of parents, pediatricians, public health program staff and others who are providing information to the Core Partner Steering Committee regarding existing barriers to access and model programs that promote access to care.
*MCSHC grantees will continue to serve as either enrollment sites for Hoosier Healthwise or they will refer clients to local Hoosier Healthwise enrollment sites.
*The Indiana Family Helpline will continue to provide referrals and screen clients for Hoosier Healthwise eligibility.
*MCSHC grantees providing primary care to children will continue to be Medicaid providers.
*Family Care Coordination grantees will have as a prime goal to facilitate children in to Hoosier Healthwise.

c. Plan for the Coming Year

FY 2006 Performance Objective: To maintain or improve the percent of Medicaid eligible children who have received a service paid by the Medicaid program to 86% in 2006.

*The MCHB funded project, the Indiana Early Childhood Comprehensive System Program includes strategies to increase the percentage of children on child care voucher programs who have a medical home.
*ECCS program will work on providing service information to families via a website.
*MCSHC grantees will continue to serve as either enrollment sites for Hoosier Healthwise or they will refer clients to local Hoosier Healthwise enrollment sites.
*The Indiana Family Helpline will continue to provide referrals and screen clients for Hoosier Healthwise eligibility.
*MCSHC grantees providing primary care to children will continue to be Medicaid providers.
*Family Care Coordination grantees continue to facilitate children in to Hoosier Healthwise.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1.3	1.3	1.2	1.2	1.3
Annual Indicator	1.4	1.4	1.4	1.4	1.4
Numerator	1214	1227	1149	1231	
Denominator	87697	86122	85107	86382	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.3	1.3	1.3	1.2	1.2

Notes - 2002

All data are for the calendar year and not the fiscal year.
Source of Numerator and Denominator: Indiana Birth Records, ISDH Epidemiology Resource Center.

FY2002 Data not yet available.

Notes - 2003

All data are for the calendar year and not the fiscal year.
Source of Numerator and Denominator: Indiana Birth Records, ISDH Epidemiology Resource Center. Percentage actually 1.38 (application program rounds up to 1.4).

Notes - 2004

2004 data not yet available. Estimate provided based on trend analysis.

a. Last Year's Accomplishments

FY 2004 Performance Objective: The percent of very low birthweight infant among all live births will decrease to 1.3% in FY 2004.

NOT MET at 1.4%

*MCSHC funded 13 prenatal direct care services to provide prenatal care to high-risk low-income pregnant women.
*Grantees are required to educate and monitor clients on preterm labor signs, risks of smoking, importance of appropriate weight gain and other issues identified in FIMR findings. Evaluation of programs done through annual report submission and MCSHC service database (FRED).
*Worked with local minority health coalitions in Lake county to provide prenatal care coordination, baby showers to outreach to high-risk women.
*Funded prenatal projects completed infant mortality, low birthweight reports on incidents that occurred at their clinic to identify causes and make necessary programmatic changes to prevent further incidences. Examples include adding extra nutritionist visits for adolescents not gaining enough weight, revision of treatment of UTI protocol to include retesting even if asymptomatic, adding new questions about substance abuse to initial visit form.
*Successful Statewide Perinatal Conference on High Risk Pregnancy held in May at the Ritz Charles.
*Three regional Perinatal Provider Education Conferences held in Vanderburgh, Porter and Vigo Counties.
*Baby First Right From the Start consumer video being revised to include periodontal health, breastfeeding, bacterial vaginosis, fatherhood and other new evidenced based perinatal practices.
*Published and distributed Indiana Perinatal Newsletter (Perinatal Perspectives) three (3) times a year on topics of folic acid, elective cesarean, perinatal Hepatitis B case management, perinatal aspects of sexually transmitted infections, new treatments for preterm labor.
*The Baby First Digital Toolkit was completed in collaboration with the School of Informatics, a graduate-level department of Indiana University Purdue University Indianapolis (IUPUI). The toolkit will be used to promote and implement Baby First in all regions of the state.
*Baby First Media Campaign implemented in Lake and Vanderburgh Counties with funding from MCSHC, ISDH Office of Minority Health and WIC.
*State Perinatal Advisory board meetings held three (3) times during the year.
*Very Low Birthweight and Breastfeeding subcommittees implemented.
*Worked with 3 Regional Perinatal Advisory Boards. Continued to try to expand region boards.
*Medicaid Family Planning Waiver not approved by General Assembly.
*Applied for Healthy Start grant for St. Joseph and Allen Counties. Was accepted but not funded.
*Facilitated Maternal Mortality Subcommittee. Executive Committee has met and policy and procedures developed, CDC abstraction modules reviewed and approved, abstraction database to be developed.
*SIDS Community Council restructured to reflect broader focus and renamed Community Council for Infant Health and Survival.
See Attachment

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. IPN will continue the Issues Commission of IPN Advisory Board with				X

First Steps staff to review VLBW issues.				
2. IPN and MCSHC will provide consultation to groups doing Fetal & Infant Mortality Reviews				X
3. MCSHC and IPN will provide protocol/guidance to ISDH funded projects and Community Health Centers.				X
4. MCSHC & CHC grantees will use the LBW & Neonatal Death Review form to evaluate system issues.				X
5. MCSHC staff will distribute PN risk assessment tool via the IPN Practice Alert to providers & OMPP.				X
6. MCSHC will provide technical assistance for the Community Health Worker training program at Ivy Tech.				X
7. MCSHC will identify common contributing factors to very low birth weight infants & collaborate with IPN.				X
8. MCSHC will expand PNCC in large minority communities utilizing Lake County's strategy.				X
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: The percent of very low birthweight infant among all live births will be maintained at 1.3% in FY 2005.

*MCSHC funded 13 prenatal direct care services to provide prenatal care to high-risk low-income pregnant women in 2005.
*Grantees are required to educate and monitor clients on preterm labor signs, risks of smoking, importance of appropriate weight gain and other issues identified in FIMR findings. Evaluation of programs done through annual report submission and MCSHC service database (FRED).
*Perinatal consultant participates in Marion County PPOR (Perinatal Periods of Risk) Data Action Working Group to evaluate and strategize results concerning infant deaths from very low birthweight.
*New Fetal Infant Mortality Reviews (FIMR) funded in Marion, Lake and St. Joseph counties, Vanderburgh County also doing a FIMR. Allen County Health Department returned funding for FIMR and did not want to participate at this time.
*Prenatal projects continue to complete infant mortality, low birthweight reports as part of their annual report on incidents that occurred at their clinic to identify causes and make necessary programmatic changes to prevent further incidences.
*State Conference: Eliminating Perinatal Health Disparities held October 1, 2004. National speakers Vajaya Hogan, Loretta Jones, and Richard Aronson presented.
*Three regional Perinatal Provider Education Conferences have been held in Porter, Vigo and Vanderburgh counties in 2005.
*Baby First Right From the Start consumer video completed and is being distributed to all pregnant women through IPN and IFHL.
*Baby First …Right From the Start multi-media campaign digital tool-kit completed and steps being taken to provide it for community implementation on the IPN website.
*Baby First Media Campaign repeated in Lake County with funding from MCSHC and ISDH Office of Minority Health.
*Continue to publish and distribute Indiana Perinatal Newsletter (Perinatal Perspectives) three (3) times a years on topics of evidence based best practices. The winter newsletter topics included perinatal disparities, centering pregnancy, unintended pregnancy.
*Convene and facilitate three (3) State Perinatal Advisory Board meetings. One meeting has occurred in February and a second meeting is scheduled for May, 2005.
*Continue to facilitate Very Low Birthweight and Breastfeeding subcommittees, developed

committees on bereavement, unintended pregnancy and perinatal depression.
*Facilitate Maternal Mortality Subcommittee. Operational Data Store (ODS) maternal mortality data cleaning and data integrating steps not completed. A temporary Access database created until the ODS is operational.
*Community Council for Infant Health and Survival conducted a state conference on Safe Sleep and bereavement on October 6, 2004. The Council began taking steps to propose legislation to make safe sleep training of daycare directors and staff mandatory.
See Attachment

c. Plan for the Coming Year

FY 2006 Performance Objective: The percent of very low birthweight infant among all live births will be maintained at 1.3% in FY 2006.
*MCSHC will extend funding to prenatal direct care services to provide prenatal care to high-risk low-income pregnant women.
*Indiana Access surveys will be completed in another high-risk county. Analysis of results and strategies will begin.
*PPOR assessment for the entire state will begin.
*Results from Marion County PPOR will be shared through IPN Newsletter. Other targeted counties will be provided technical assistance to begin local PPOR (Perinatal Periods of Risk).
*Prenatal projects will continue to examine all cases of infant mortality and low birthweight occurring in their clinic to find commonalities and causes to develop strategies to improve clinic outcomes.
*Funded FIMR reviews will continue in targeted counties (Allen, Marion, Lake, St. Joseph, and Vanderburgh Counties).
*Combine FIMR and CFR reports and recommendations at the state level.
*State Conference on Perinatal Bereavement to be held in the fall.
*Continue to facilitate three regional Perinatal Provider Education Conferences on latest research and recommendations yearly.
*Update Baby First media campaign, consumer video and educational handouts to correspond to new best practices as needed.
*Convene issues subcommittees of the State Perinatal Advisory Board on unintended pregnancy/birth spacing, environmental hazards and pregnancy, mental health/substance abuse.
*Maternal Mortality Subcommittee will release its first report.
*Community Council on Infant Health and Survival will convene subcommittees on accurate death certificate information training, education for providers on safe sleep, plan for a conference on best practices for safe sleep and other infant death prevention based on early FIMR reports.
*Medicaid Family Planning Waiver will be approved and implemented.
*Child Spacing Educational Campaign will begin statewide.
*Doula pilot program will be implemented in Marion County and evaluation begun.
*MCSHC will continue to maintain an up-to-data database of all infant deaths. The Access data program will be incorporated into the Operational Data Store (ODS) system when available.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2000	2001	2002	2003	2004

Data					
Annual Performance Objective	7.3	7.1	6.9	8	8
Annual Indicator	8.7	9.0	9.1	6.6	8.4
Numerator	39	41	40	29	
Denominator	446558	453482	440239	442311	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8	8	7.8	7.8	7.6

Notes - 2002
All data are for the calendar year and not the fiscal year.
Source of Numerator and Denominator: Indiana Birth Records, ISDH Epidemiology Resource Center.

FY 2002 data not yet available.

Notes - 2003
All data are for the calendar year and not the fiscal year.

Source of Data: ISDH ERC.

Notes - 2004
All data are for the calendar year and not the fiscal year.

Source of Data: ISDH ERC.

2004 data not yet available. Estimate provided based on trend analysis.

a. Last Year's Accomplishments

FY 2004 Performance Objective: The rate of suicide deaths among youths aged 15-19 will decrease to 8.0 by the end of FY 2004.

NOT MET at 8.4

*Funding provided for a 0.5 FTE Administrative Coordinator for the Indiana Suicide Prevention Coalition.
*The Coalition above developed and promotes a state Suicide Prevention Plan
*Eight regional suicide coalitions have been established throughout the state
*The Suicide Prevention Coalition has matured from a volunteer group to a State sponsored coalition. Funding support was secured from MCSHC, which enabled the hiring of an administrative coordinator to be able to accomplish continued organizational growth. A mission statement and goals for the Coalition have been accomplished.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			

	DHC	ES	PBS	IB
1. The Suicide Prevention Coalition will continue to function as an "umbrella" organization for regional coalitions.				X
2. The Coalition became incorporated and is funded through an MCHB grant.				X
3. The coalition will promote the Suicide Prevention State Plan.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: The rate of suicide deaths among youths aged 15-19 will be maintained at 8.0 in FY 2005.

*MCSHC will continue funding the 0.5 FTE Administrative Coordinator for the Indiana Suicide Prevention Coalition. The Coalition will continue to function as an "umbrella" organization for 8 regional coalitions
*Statewide assessment of youth suicide resources being completed by the Coalition.
*Indiana Suicide Prevention Coalition website is developed and operational. The url is www.indianasuicidepreventioncoalition.org
*Injury Prevention Program Director participated in the ASTHO Collaboration Around Youth Suicide Prevention, along with other Coalition members
*The State Suicide Prevention Plan is being disseminated to appropriate MCSHC Projects. Teen suicide is one of the five injury problems addressed in the Plan.
*Analysis of the 2002 hospital discharge database for patients admitted for attempted suicide was completed, demonstrating that poisoning (medication overdoses) accounted for 93% of self-inflicted injury hospitalizations.

c. Plan for the Coming Year

FY 2006 Performance Objective: The rate of suicide deaths among youths aged 15-19 will be maintained at 8.0 in FY 2006.

*Convert draft version of a State Injury Prevention and Control Plan to a final document, and begin implementation efforts. Of the five injury problems addressed in the Plan, one objective is to reduce the number of teen suicide deaths by X% (to be determined).
*Continue collaboration with the Indiana Suicide Prevention Coalition in implementation of the State Suicide Prevention Plan.
*Indiana organizations or agencies will submit at least one application for funding to the Garrett Lee Smith grant funding offered through Substance Abuse and Mental Health Services Administration.
*Collaboration with the Indiana Suicide Prevention Coalition in the review and publication of data obtained from the statewide assessment of youth suicide resources being completed by the Coalition
*The Injury Prevention Program will publish an updated version of the Suicide in Indiana data report.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	56.5	57	57.5	58	58
Annual Indicator	54.6	53.6	56.4	76.4	76.4
Numerator	663	658	664	941	
Denominator	1214	1227	1177	1231	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	77	77	77.5	78	78.5

Notes - 2002

All data are for the calendar year and not the fiscal year.
Source of Numerator and Denominator: Indiana Birth Records, ISDH Epidemiology Resource Center.

The numerator is total number of occurrent births of Very Low Birth Weight at hospitals who have self-declared their status as a level 3 hospital. Although Indiana does not have a formal perinatal system in place, the Indiana Perinatal Network conducted a new survey in FY 2001 which requested that hospitals identify their level according to established standards. The denominator is the total occurent births of Very Low Birth Weight.

Notes - 2003

All data are for the calendar year and not the fiscal year.
Source of Numerator and Denominator: Indiana Birth Records, ISDH Epidemiology Resource Center.

The numerator is total number of occurrent births of Very Low Birth Weight at hospitals who have self-declared their status as a level 3 hospital. Although Indiana does not have a formal perinatal system in place, the Indiana Perinatal Network conducted a new survey in FY 2003 which requested that hospitals identify their level according to established standards. The denominator is the total occurent births of Very Low Birth Weight.

A number of additional hospitals indentified themselves as level three in 2003 accounting for a significant increase in this figure. Objective for 2004 should be 76.4. Application would not allow change.

Notes - 2004

All data are for the calendar year and not the fiscal year.
Source of Numerator and Denominator: Indiana Birth Records, ISDH Epidemiology Resource Center.

The numerator is total number of occurrent births of Very Low Birth Weight at hospitals who have self-declared their status as a level 3 hospital. Although Indiana does not have a formal perinatal system in place, the Indiana Perinatal Network conducted a new survey in FY 2003 which requested that hospitals identify their level according to established standards. The denominator is the total occurent births of Very Low Birth Weight.

2004 data not yet available. Estimate provided based on trend analysis.

a. Last Year's Accomplishments

FY 2004 Performance Objective: The percent of very low birthweight infants delivered at facilities for high-risk deliveries and neonates will increase to 58% in CY 2004.

OBJECTIVE MET at 76.4%

*Hospitals reassessed for levels of care. This has changed the numerator, resulting in a dramatic increase in the number of hospitals with self-reported facilities for high-risk deliveries and neonates.
*Final draft of Levels of Hospital Perinatal Care Consensus Statement and Best Practice Guideline in Indiana reviewed by Commissioner and MCSHC Medical Director and minor changes made.
*Prenatal Continuing Education Program (PCEP), assists in ensuring that all women receive risk appropriate care and appropriate maternal and neonate transport. PCEP training completed in 3 counties in 2004..
*State Newborn Intensive Care Unit (NICU) Developmental Care Conference for providers was held on April 19, 2004.
*Neonatal Perinatal Consortium: Making a difference held April 21, 2004.
*Professional education continued through release of Perinatal Perspective Newsletter, regional and state conference, web site and reports and consensus statements.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to fund the IPN to assist with Infrastructure Building & Population-Based Services education.				X
2. Publish quality standards for each level of hospital care based on IPN Advisory Board consensus & recommendations.				X
3. Establish framework based on 2003 Hospital Survey to ensure pregnant women deliver in appropriate hospitals.				X
4. Continue to implement the Prenatal Continuing Education Program (PCEP) as a standard hospital curriculum.				X
5. Encourage all level 3 and level 2 hospitals to participate in PCEP training.				X
6. Monitor implementation of Guidelines by hospitals.				X
7. Assist hospitals to develop regional centers for high-risk deliveries and neonates.				X
8.				
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: The percent of very low birthweight infant delivered at facilities for high-risk deliveries and neonates will increase to 77% in CY 2005.

*Levels of Hospital Perinatal Care Consensus Statement and Best Practice Guideline sent to hospitals one last time for updates. IPN will publish the Levels of Care document along with 3 years of low birthweight statistics.
*Prenatal Continuing Education Program (PCEP) begun in Allen, Dekalb, and Kosciusko Counties.
*Indiana Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) has now come under the Indiana Perinatal Network. They have conducted a Fetal Monitoring Class on January 20-21, 2005, and Basic Fetal Monitoring on February 3, 2005.

c. Plan for the Coming Year

FY 2006 Performance Objective: The percent of very low birthweight infant delivered at facilities for high-risk deliveries and neonates will be maintained at 77% in CY 2005.

*Review FIMR data for appropriate deliveries and transport of high-risk deliveries and neonates.
*Continue to implement through IPN Prenatal Continuing Education Program (PCEP) in 3 more counties.
*Continue trainings on appropriate transfer of high-risk deliveries and neonates through IPN.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	78.2	78.4	80	80.2	80.4
Annual Indicator	79.4	78.8	80.5	80.6	81
Numerator	69642	67835	68330	69605	
Denominator	87697	86122	84839	86382	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	81.1	81.2	81.3	81.4	81.5

Notes - 2002

All data are for the calendar year and not the fiscal year.
Source of Numerator and Denominator: Indiana Birth Records, ISDH Epidemiology Resource

Center. FY 2002 data unavailable at present.

Notes - 2003

All data are for the calendar year and not the fiscal year.
Source of Numerator and Denominator: Indiana Birth Records, ISDH Epidemiology Resource Center.

Notes - 2004

2004 data not yet available. Estimate provided based on trend analysis.

a. Last Year's Accomplishments

FY 2004 Performance Objective: The percent of infants born to pregnant women initiating prenatal care in the first trimester of pregnancy will increase to 80.4% in FY 2004.

OBJECTIVE MET at 81%

*MCSHC funded twenty-two (22) prenatal care coordination services projects to provide outreach, case management, referral and education to high-risk pregnant women.
*An Hispanic prenatal care coordination team, "Promatoras de Salud" was funded in East Chicago in Lake County.
*Provided ongoing technical assistance to mobilize community partnerships for the Lake County MCH Network.
*MCSHC consultant worked with Office of Medicaid Policy and Planning and three (3) Medicaid Managed Care Organizations (MCOs) to revise and publish the Prenatal Risk Assessment Tool that includes psycho-social determinants, develop guidelines for contracting with local prenatal care coordinators, developed new forms to meet the data requirements of the MCOs.
*Prenatal Care Coordination Certification (PNCC) Training revised into a 2-day training with collaboration from the Office of Medicaid Policy and Planning, three Medicaid MCOs, and the Indiana National Social Workers Association.
*Community Health Worker (CHW) training materials revised and piloted at IVY TECH Community College in Lake County in October- January. Twenty one CHWs certified.
*A Mini-PRAMS Survey was begun in LaPorte County. Materials and technical assistance given to persons in Allen County to implement the survey.
*Mini-PRAMS analysis from Lake, Marion and St. Joseph counties shared with county stakeholders.
*Indiana Access completed 493 pediatric surveys at 4 community health centers in Marion County and 523 prenatal/postpartum surveys at two Marion County hospitals targeting minority women on Medicaid. Frequencies released.
*IPN in collaboration with ISDH applied for a new Healthy Start grant to provide Healthy Start services in Allen and St. Joseph Counties. The grant was accepted but not funded.
*Facilitated Maternal Mortality Subcommittee. The Executive Committee met and developed policy and procedures, CDC abstraction modules reviewed and approved, abstraction database to be developed.
*ISDH in collaboration with IPN, University of Indianapolis, Marion County Health Department, Methodist and Wishard Hospitals, I.U. School of Nursing, local prenatal care coordinators, and Healthy Family workers formed a committee to plan a community health worker Doula pilot project.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCSHC grantees that provide Prenatal Care services will participate in all Population-Based Services perinatal education.	X			

2. MCSHC grantees will contribute to regional Infrastructure Building by participating in an IPN Regional Advisory Board & community groups.				X
3. MCHSC grantees may expand services to offer a basic 1st Prenatal visit services while pregnant women await MD appointments.	X			
4. MCSHC will expand funded projects (as funding is available into more high-risk GIS identified areas.)				X
5. MCSHC will continue to increase Prenatal Care Coordination and outreach in high priority counties.				X
6. MCSHC will continue to standardize Prenatal Care Coordination and work with Medicaid.				X
7. MCSHC will facilitate the successful Lake County MCH Network for Prenatal Care Coordination to other counties.				X
8.				
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: The percent of infants born to pregnant women initiating prenatal care in the first trimester of pregnancy will increase to 81.1% in FY 2005.

*MCSHC continues to fund twenty-two (22) prenatal care coordination projects around the state to provide outreach, case management, referral and education to high-risk pregnant women.
*MCSHC consultant continues ongoing technical assistance to mobilize community partnerships with the Lake County MCH Network. The Network has successfully collaborated with local Division of Family and Children to reduce time from Medicaid enrollment to obtaining Medicaid card from 6 weeks to 1-2 weeks. The Network has successfully collaborated with the Calumet Township Trustee to provide outreach and case management services on site at the Trustee Office.
*MCSHC consultant continued to work with Office of Medicaid Policy and Planning (OMPP) and three (3) Medicaid Managed Care Organizations (MCOs) until January when OMPP consultant left, and 2 new Medicaid MCOs contracted with for a total of five. Will restart group meetings in April with new OMPP consultant and new MCOs to rewrite Administrative Rule governing prenatal care coordination.
*Revised Prenatal Care Coordination Certification (PNCC) Training offered three times a year. The new training was piloted in November, 2004
*Community Health Worker (CHW) training is being standardized. Working with the Indiana Minority Health Coalition to collaborate on trainings.
*MCSHC funded Memorial Hospital in St. Joseph County to work with the faith based community in a targeted neighborhood to train community health workers that will outreach to church members and surrounding neighborhood residents.
*The post partum survey of the LaPorte Mini PRAMS survey completed and data being analyzed. The 3-month follow-survey in progress. Allen County has not implemented the survey as yet due to an outbreak of TB that has tied up the local health department staff.
*Extensive review of Indiana Access survey results shared with ISDH and county stakeholders. Plans to replicate the survey have been delayed until 2006 due to problems finding surveyors to finish the original surveys according to timeline.
*Indiana Access cultural competency training in phase 2 at four (4) community health centers in Marion County.
*Marion County Healthy Start has started a Baby First Advocacy Program with volunteers from identified high-risk neighborhoods to provide outreach and community education on perinatal issues and facilitate early entrance into prenatal care. MCSHC, IPN, and Healthy Start will collaborate to replicate this model in another county.

*IU School of Nursing funded to evaluate the efficacy of three (3) funded community-based outreach pilot projects: Baby Advocates in Marion County, Faith-based community health worker project in St. Joseph County, and Westside neighborhood investment center free pregnancy testing program.
See Attachment

c. Plan for the Coming Year

FY 2006 Performance Objective: The percent of infants born to pregnant women initiating prenatal care in the first trimester of pregnancy will increase to 81.2% in 2006.

*MCSHC will extend funding for prenatal care coordination services to provide outreach, case management, referral and education to high-risk pregnant women.
*MCSHC consultant will continue to work closely with the Healthy Start projects in Lake County and Marion County to address county needs.
*MCSHC consultant will continue to work closely with the Lake County MCH Network to explore ways the county can address and fund access to prenatal care issues and reduce perinatal disparities.
*MCSHC consultant will continue to work with Office of Medicaid Policy and Planning (OMPP) and five (5) Medicaid Managed Care Organizations (MCOs) to develop policies that facilitate early entrance into prenatal care for our MCH populations and that continue to provide reimbursement for prenatal care coordination and community health workers at the local level.
*Medicaid Administrative Rule to continue and enhance prenatal care coordination reimbursement will be finalized.
*Develop system with OMPP and MCOs to collect prenatal care coordination outcome data.
*Indiana Access survey will be completed in at least one other of the five targeted counties (Allen, Elkhart, Lake, or St. Joseph).
*At least 1 agency in two of the targeted counties (Allen, Elkhart, Lake, St. Joseph) will initiate phase 1 of Indiana Friendly Access training.
*Implement Mini-PRAMS survey in another county.
*PNCC training updated as needed. Recertification of original PNCCs certified will be implemented to update knowledge of latest best practices in prenatal care.
*CHW Train-The-Trainer program will be completed and MOUs completed with regional agencies to train CHWs with standardized curriculum.
*IU School of Nursing report on findings of three outreach projects will be completed and findings shared with counties as best practice models for outreach.
*Doula training, implementation at two pilot sites in process, evaluation ongoing.
*MCSHC will attempt to collaborate again with the Office of Medicaid Policy and Planning and three Medicaid Managed Care Organizations in Lake County to initiate a pilot program to evaluate the effect of the Medicaid managed care system on obtaining Medicaid cards in a timely fashion, enrollment in MCO in first trimester, efficacy of outreach and home visiting services to identified high-risk pregnant women in the Medicaid MCO system.

D. STATE PERFORMANCE MEASURES

State Performance Measure 9: *Establish a system of routine data access with internal and external data sources.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2000	2001	2002	2003	2004

Data					
Annual Performance Objective		1	2	3	4
Annual Indicator		2	3	4	16
Numerator		2	3	4	16
Denominator	5	5	5	5	5
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	17	18	19	20	21

Notes - 2003

For 2003 the figure is based on the previous five-part scale of data access measures. This scale is anticipated to be modified during the next fiscal year to align it with the HSCI as listed in Form 19.

Notes - 2004

See note from 2003.

The figure is no longer based on the previous five-part scale of data access measures. This scale has been modified during this fiscal year to align it with the correlated HSCI as listed in Form 19. The denominator should be 21. Application would not allow change.

a. Last Year's Accomplishments

FY 2004 Performance Objective: MCSHCS will complete at least three of five data access measures by the end of FY 2004.

Objective was met.
*MCSHC developed a MOU with Office of Medicaid Policy and Planning that now includes for the first time routine and timely access to Medicaid data.
*MCSHC developed procedures for regular communication among the ISDH Epidemiology Resource Center, MCSHC, and the Indiana Health and Hospital Association and began data sharing.
*MCSHC began implementing the Lead surveillance part of the ODS development as well as Data Marts for the IBDPR and NBS. Refinement of data from NBS labs, hospital discharges, and Vital Statistics for future integration into the ODS was begun.
*The Data Integration Steering Committee and Data Integration Steering Committee Executive Team were revised and merged to better coordinate the ODS development efforts.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Continue to expand the ODS & develop data marts for additional progams including chronic disease, immunization, & Vital Statistics.				**X**
2.				
3.				

4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: MCSHCS will complete at least four of five data access measures by the end of FY 2005.

*MCSHC continues to expand and define the ODS and is now successfully importing data related to the Lead screening program as well as testing the beta-revised first Data Mart for Newborn Screening output.
*MCSHC is developing additional Data Marts for other programs including Universal Newborn Hearing Screening and preliminary work on the chronic disease, immunization, and the new vital statistics system parts of the ODS.
*The Data Integration Steering Committee was restructured and began meeting monthly to guide the agency-wide Data Integration effort. This allows MCSHC to complete four of the five data access measures, thus meeting the 2005 goal.
*MCSHC is revising this performance measure to expand beyond the five data access measures to reflect the complexity and progress of the Data Integration project.

c. Plan for the Coming Year

The new SP #01, based on a sixteen-part measurement scale, will begin in 2006.

Planned activities for all new State Negotiated Performance Measures are appended to the FY 2006 5-Year Needs Assessment.

State Performance Measure 10: *The rate per 10,000 for asthma hospitalizations (ICD 9 Codes: 493.0 - 493.9) among children less than five years old.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		78.5	76.8	75.1	73.3
Annual Indicator	76.0	75.4	74.8	38.7	38.7
Numerator	3216	3263	3213	1664	
Denominator	423215	432755	429293	430166	
Is the Data Provisional or Final?				Final	Provisional

	2005	2006	2007	2008	2009
Annual Performance Objective	38	37	37	36	36

Notes - 2002

Source of Numerator and Denominator: Indiana Hospital Discharge Records, ISDH Epidemiology Resource Center. 1994 was the only year for which data was available until recently, when the ISDH ERC succeeded in obtaining data for 1998, 1999, and 2000. It is unknown when additional data from the IHDR will become available, but it is believed that actual discharge data will be available in fall of 2003. The figure is a provisional projection based on multi-year trends.

Notes - 2003

Actual data received beginning in 2003. Previous estimates and projections were inflated due to Health and Hospital Corporation providing counts which included duplicates.

Source of data: ISDH Chronic Disease Program

Notes - 2004

Actual data received beginning in 2003. Previous estimates and projections were inflated due to Health and Hospital Corporation providing counts which included duplicates.

Source of data: ISDH Chronic Disease Program

Data for 2004 not yet available. Estimate provided based on previous year baseline.

a. Last Year's Accomplishments

FY 2004 Performance Measure: The rate per 10,000 for diagnosed asthma hospitalization among children less than five years old will decrease to 73.3 in CY 2004.

OBJECTIVE MET at 38.7%

*Actual data received beginning FY 2003. Previous estimates and projections were inflated due to Health and Hospital Corporation providing counts which included duplicates.
*The ISDH and the Indiana Department of Environmental Management (IDEM) formed the Indiana Joint Asthma Coalition (InJAC). The InJAC has five working groups: Data & Surveillance, Children & Youth, Public Education, Environmental Quality and Health Care Providers.
*A Draft Asthma State Plan was produced by September 2004.
*Hoosier Healthwise and ISDH developed an Asthma Case Management Program. The Health Care Provider Workgroup developed provider and patient materials for an asthma tool kit. Training was held for medical practices around the state.
*An asthma burden report was developed and used by the workgroups during FY 2004 as they developed the state plan.
*ISDH and IDEM and InJAC partnered to develop a web-based environmental triggers tool with the assistance of an EPA grant. The tool has various components targeting housing (landlords/renters), schools, child care providers, caretakers of asthmatics, and medical providers. It can be found at http://www.in.gov/idem/breatheasyville/nonflashcity.html

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Continue data-sharing linkage between IHHA & ISDH Epidemiology Resource Center.				X
2. Annually update asthma burden report.				X
3. Indiana Joint Asthma Coalition (InJAC) will promote evidence-based guidelines for MDs.				X
4. Begin implementing the State Asthma Plan through InJAC.				X
5. Continue implementing the asthma surveillance reporting system.				X
6. Identify priority populations for greatest risk of mortality and morbidity.				X
7. Determine organizations and agencies that can assist with implementation of strategies.				X
8. Continue to disseminate educational materials on environmental asthma triggers.			X	
9.				
10.				

b. Current Activities

FY 2005 Performance Measure: The rate per 10,000 for diagnosed asthma hospitalization among children less than five years old will decrease to 38.0 in CY 2005.

*The Indiana State Health Commissioner and the Commissioner of the Indiana Department of Environmental Management approved the Strategic Plan for Addressing Asthma in December 2004. It is available at: http://www.in.gov/isdh/programs/asthma/pdfs/IndianaAsthmaPlan.pdf
*The Indiana Asthma Program and InJAC published The Burden of Asthma in Indiana in January 2005. It is available at the ISDH website, http://www.in.gov/isdh/programs/asthma/index.htm.
*The rest of this year, InJAC workgroups with state asthma program staff will begin implementing objectives outlined in the state plan.

c. Plan for the Coming Year

*This SP will continue as SP 02.

Planned activities for all new State Negotiated Performance Measures are appended to the FY 2006 5-Year Needs Assessment.

State Performance Measure 11: *The percent of live births to mothers who smoke.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	20.7	20.4	20.1	19.8	19.5
Annual Indicator	20.2	20.2	19.1	18.5	18.0
Numerator	17722	17380	16210	15954	15807

Denominator	87697	86122	84744	86382	87927
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	17.8	17.6	17.4	17.2	17

Notes - 2002

Source of data: Indiana ERC. Data for FY2002 unavailable at this time.

Notes - 2003

Source of data: ERC.

Notes - 2004

Data not available for 2004. Estimate provided base don trend analysis.

a. Last Year's Accomplishments

FY 2004 Performance Objective: Decrease the percent of mothers with live births who smoke to 19.5% in CY 2004.

OBJECTIVE MET at 18

*The ISDH Prenatal Substance Use Prevention Program (PSUPP) identified 3,561 high-risk, chemically dependent pregnant women.
*PSUPP held two smoking cessation workshops in Gary, 4-2-04 and Indianapolis, 4-28-04, for providers working with pregnant women and women of childbearing age.
*The "You and Me Smoke-Free" material was presented by an MCSHC consultant to prenatal care providers at another 3 trainings in 2004.
*PSUPP screened and educated 3,561 pregnant women on the possible hazards of using alcohol, tobacco and other drugs during pregnancy.
*PSUPP participated in 142 community events, health fairs, conferences, and other public forums.
*PSUPP distributed 4,071 educational items to providers indicating the importance of identifying at-risk clients.
*PSUPP offered smoking cessation materials to private physician offices.
*PSUPP distributed 29,492 informational items about the impact of substance use among pregnant women to the public.
*Funding for the PSUPP clinics was provided by the Indiana Division of Mental Health with Federal Funds from the Center for Substance Abuse Prevention and the Indiana Tobacco Prevention and Cessation Agency (ITPC).

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. PSUPP grantees will continue with funds from FSSA DMHA, ITPC, & Title V.	**X**			
2. Continue Prenatal Smoking Cessation Trainings using ITPC funds that are open to MCSHC staff.				**X**
3. Bowen Center at IUPUI will evaluate PSUPP.				**X**

4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: Decrease the percent of mothers with live births who smoke to 17.8% in CY 2005.

* The ISDH Prenatal Substance Use Prevention Program (PSUPP) will identify high-risk chemically dependent pregnant women.
*PSUPP will hold two smoking cessation workshops for providers working with pregnant women and women of childbearing age.
*MCSHC consultant will continue to provide training on "You and Me Smoke-Free" program and on the "ASK" Protocol.
*PSUPP will educate women of childbearing age on the possible hazards of using alcohol, tobacco and other drugs during pregnancy.
*PSUPP will continue to participate in community events, health fairs, conferences, and other public forums.
*PSUPP will distribute educational items to providers indicating the importance of identifying at-risk clients.
*PSUPP will offer smoking cessation materials to private physician offices.
*PSUPP will distribute informational items about the impact of substance use among pregnant women to the public.
*PSUPP clinics (3) will provide support groups for women in substance use cessation.
*Terry Zollinger and Associates at the Bowen Center of Indiana University and Purdue University, Indianapolis will continue to perform the data collection process for the PSUPP clinic.
*Indiana Perinatal Network (IPN) will publish a practice alert on evidenced smoking cessation materials for prenatal care providers.
*The "ASK" Protocol and the "You and Me Smoke-Free" brochures will available to download on the IPN website.
*MCSHC will provide web-based training for providers for smoking cessation for pregnant women "Smoking Cessation for Pregnancy and Beyond--Learn Proven Strategies to Help Your Patients Quit".
*PSUPP will continue to be funded by the Division of Mental Health with Federal funds from the Center for Substance Use Prevention and MCSHC.

c. Plan for the Coming Year

*This objective will be continued as SP 03.

Planned activities for all new State Negotiated Performance Measures are appended to the FY 2006 5-Year Needs Assessment.

State Performance Measure 12: *The percent of black women (15 through 44) with a live birth whose prenatal care visits were adequate.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		64	65	66	67
Annual Indicator	60.2	63.2	61.6	61.6	61.7
Numerator	5671	6023	5694	5722	
Denominator	9421	9531	9243	9288	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	62	63	64	65	66

Notes - 2002

Source of Percentage: Indiana Birth Records, ISDH Epidemiology Resource Center. FY 2002 data unavailable at present.

Notes - 2003

Numerator is a calculated value.

Source of data: ERC.

Notes - 2004

Data not available. Estimate provided based on trend analysis.

a. Last Year's Accomplishments

FY 2004 Performance Objective: The percent of Black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate will increase to 67% in FY 2004.

NOT MET at 61.7%

*The Office if Minority Health (OMH) executed and developed a program that contained the initiation and retention of African American mothers to breastfeed their infants through the first six months of life. The"Grandmothers' Tea…Would You Like Milk With Tea?" was replicated in 2004 in three cities in the state, Indianapolis, Lafayette, (had one in English and one in Spanish) and South Bend, IN.
*During the events, Grandmothers had the opportunity to learn about the benefits of breastfeeding, and other attributes to infants who are breastfed vs. those infants who are not. Most importantly, Grandmothers learn to build a foundation of support for breastfeeding mothers.
*Indiana Perinatal Network (IPN) and MCSHC sponsored a booth at the Indiana Black Expo Black and Minority Health Fair to educate attendees regarding the need for early and adequate prenatal care and safe sleep practices.
*The OMH coordinated a project to translate Indiana's public health information into Spanish during 2004. Several program areas benefited from this effort to produce general consumer information, health program announcements and the department's web site.
*Free bi-lingual interpretation training was provided to 25 persons from local health

departments, community health centers, MCSHC funded projects, etc by the Office of Minority Health in partnership with the Indiana Primary Health Care Association and included 1) basic interpreting skills (role, ethics, conduit and clarifier interpreting, intervening, managing the flow of the session); 2) information on health care (introduction to the health care system, how doctors think, anatomy, basic medical procedures); 3) culture in interpreting (self-awareness, basic characteristics of specific cultures, traditional health care in specific communities, culture-brokering); 4) communication skills for advocacy (listening skills, communication styles, appropriate advocacy); and 5) professional development.
*As one of five states chosen to participate in the Association of Maternal and Child Health Programs (AMCHP) Action Learning Lab (ALL) on Reducing Perinatal Disparities, the Indiana ALL State Team created an Action Plan to reduce African American perinatal disparities in five targeted counties of Allen, Elkhart, Lake, Marion and St. Joseph counties. As part of that plan:
*The plan was presented to groups in each of the five counties.
*Focus groups in Marion and Lake Counties were begun to obtain information from African American women on their perceptions of pregnancy, prenatal care, racial cultural, and financial barriers surrounding pregnancy and prenatal care.
*Comprehensive final draft perinatal data books utilizing state data were completed in September 2004.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCSHC will support ISDH Office of Minority Health (OMH) "Shower Your Baby With Love--Baby Shower" into expanded cities.				X
2. IPN's Baby First Media Campaign will be continued in Gary, IN.			X	
3. OMH and Indiana Primary Health Care Association will provide free bi-lingual medical interpreter training to Local Health Departments & Community Health Centers.			X	
4. MCSHC grantees continue to receive cultural diversity training.				X
5. Promote the Healthy Indiana Minority Health Plan to address racial and ethnic health disparities and strategies for intervention and improved health status indicators.				X
6. Implement doula pilot projects in Indianapolis.				X
7. MCSHC and IPN continue to assist high risk counties to develop local plans to reduce perinatal disparities.				X
8.				
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: The percent of Black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate will increase to 62% in FY 2005.

*The Office of Minority Health (OMH) will duplicate The"Grandmothers' Tea…Would You Like Milk With Tea?" a program that contained the initiation and retention of African American mothers to breastfeed their infants through the first six months of life in Indianapolis, Lafayette, and South Bend, IN. This program is on hold until the Office of Minority Health hires a new program consultant to conduct the showers
*OMH partnered with Methodist Hospital and the Father Resource & Research Center to

initiated a father support group for breastfeeding. The pilot ran from August 2004 to October 2004 to promote breastfeeding and increase breastfeeding rates among all black women.
*MCSHC will promote the 4th annual Shower Your Baby with Love, Baby Shower in collaboration with OMH and high-risk counties. Baby showers were held in Lake and Marion counties in May 2005.
*As one of five states chosen to participate in the Association of Maternal and Child Health Programs (AMCHP) Action Learning Lab (ALL) on Reducing Perinatal Disparities, the Indiana ALL State Team developed a logic model to decrease African American perinatal disparities in Allen, Elkhart, Lake, Marion and St. Joseph counties. Activities from the Logic model include:
*Focus groups were completed with a total of 130 women in Marion and Lake Counties. Women were stratified into groups by race (white, black, Hispanic), age (teen, non teen), and pregnant or postpartum.
*12 Community Forums were conducted in six counties (Allen, Elkhart, Lake, Marion, St. Joseph, and Vanderburgh) to obtain testimony of perceptions and experiences with the current local health system, the state of being pregnant, self-care and healthy communities. The overall top three major themes were 1) supportive behaviors from family, friends, and care coordinators/community health workers, 2) Caring clinical providers, 3) Access to care/barriers.
*Perinatal data books for the five target counties completed and shared with county stakeholders
*Information about perinatal disparities among African American women will be shared through the MCSHC sponsored booth at the Indiana Black Expo Black and Minority Health Fair.
*MCSHC consultant has met with the State Minority Health Coalition to collaborate on efforts to address disparities in Allen, Elkhart, Lake, Marion and St. Joseph counties.

c. Plan for the Coming Year

*This SP will continue as SP 04.

Planned activities for all new State Negotiated Performance Measures are appended to the FY 2006 5-Year Needs Assessment.

State Performance Measure 13: *The degree to which the State assures family participation in program and policy activities in the State MCH program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		6	10	10	11
Annual Indicator		8	9	10	11
Numerator		8	9	10	11
Denominator	18	18	18	18	18
Is the Data Provisional or Final?				Final	Final

	2005	2006	2007	2008	2009
Annual Performance Objective	13	14	15	16	18

Notes - 2003

The six characteristics documenting family participation in MCH programs are as follows, graded on a scale of 0-3, with 0 being not met, 1 being partially met, 2 being mostly met and 3 being completely met:

1. Family members participate on advisory committees or task forces and are offered training, mentoring, and reimbursement when appropriate. Score: 2.

2. Financial support (grants, technical assistance, travel, child care) is offered for parent activities or parent groups. Score: 1.

3. Family members are involved in MCH services block grant application process. Score: 1.

4. Family members are involved in inservice training of MCH staff and providers. Score: 1.

5. Famly members are hired as paid staff or consultants to the State MCH program (hired for expertise as a family member). Score: 2.

6. Family members of diverse cultures are involved in all of the above activities. Score: 3.

Total score: 10

Notes - 2004

The six characteristics documenting family participation in MCH programs are as follows, graded on a scale of 0-3, with 0 being not met, 1 being partially met, 2 being mostly met and 3 being completely met:

1. Family members participate on advisory committees or task forces and are offered training, mentoring, and reimbursement when appropriate. Score: 3.

2. Financial support (grants, technical assistance, travel, child care) is offered for parent activities or parent groups. Score: 2.

3. Family members are involved in MCH services block grant application process. Score: 1.

4. Family members are involved in inservice training of MCH staff and providers. Score: 1.

5. Famly members are hired as paid staff or consultants to the State MCH program (hired for expertise as a family member). Score: 2.

6. Family members of diverse cultures are involved in all of the above activities. Score: 2.

Total score: 11

a. Last Year's Accomplishments

FY 2004 Performance Objective: The Indiana MCSHCS will increase parental involvement in the program to "11" degree points by the end of the fiscal year 2004.

OBJECTIVE MET at 11 points

*Employees were asked to submit their perceived health priorities for the Needs Assessment.

*Consumers and parents continued to serve on the Indiana Genetic Advisory Committee, the Universal Newborn Hearing Screening Advisory Board, the Newborn Screening Advisory Board, the SIDS Community Advisory Council, the Early Childhood Comprehensive Systems project, and other ad hoc task forces that are developed.
*Parents were involved in the development of the State Asthma Plan and the Early Childhood Comprehensive System project.
*Universal Newborn Hearing Screening Program sponsored, along with the Outreach Services for the Deaf and Hard of Hearing, First Steps, and the parent focus group, a Family Conference weekend for 30 families with newly identified children with hearing loss in July, 2004. The families stayed at the Indiana School for the Deaf (ISD) where the conference was held.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Volunteers and employees who use or have used MCSHC or WIC service will be asked to provide input on progam development		X		
2. Consumers & parents will be included on the Advisory Boards of: Genetics, UNHS, NBS, et al.				X
3. MCSHC will provide reimbursement for consumer participation in statewide policy-making activities.		X		
4. Grantees continue to be required to report on client satisfaction surveys as part of their annual reports.				X
5. Parental involvement in development of the State Asthma Plan & the Early Childhood Comprehensive Systems Plan will continue.				X
6. UNHS screening will support Family Conference facilitated by Family Focus Group and IN School for the Deaf.				X
7.				
8.				
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: The Indiana MCSHCS will improve parental involvement in the program by progressing to"13" degree points by the end of the fiscal year 2005.

*Volunteers from current employees who use or have used MCSHCS or WIC services were asked to test the q-sort survey and to submit a q-sort survey for the Needs Assessment.
*Consumers and parents continue to serve on the Indiana Genetics Advisory Committee, the Early Hearing Detection and Intervention Advisory Committee, the Newborn Screening Advisory Board, the SIDS Community Advisory Council, the Child Care Health Consultant Advisory Committee and other ad hoc task forces that are developed.
*Reimbursement is made for consumer participation in statewide policy-making activities.
*Grantees continue to be required to report on client satisfaction surveys as part of their annual report.
*Parents continue to be involved in the implementation of the State Asthma Plan and the Early Childhood Comprehensive System (ECCS) project.
*The ECCS project continues Parent Mentoring program to encourage involvement of other parents on Subcommittees and at Town Meetings.
*MCSHC/NBS is supporting the Family Conference in July 2005 for 20 families with infants

newly diagnosed with hearing loss, held and co-sponsored by ISD.
*MCSHC also supports and provides a Board member of the Indiana Chapter of Hands and Voices, which provides parent support, advocacy and information.
*NBS funded SKI*HI training of professionals and parents familiar with hearing loss. This training made them eligible for First Steps Provider enrollment. This helps to build the infrastructure for improving early intervention services to families with children with hearing loss.

c. Plan for the Coming Year

This SP will be discontinued and not replaced.

State Performance Measure 14: *The number of children (6 months to 6 years) on Medicaid screened for blood lead levels.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		15000	15000	15000	17500
Annual Indicator		12741	13378	41182	43137
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.5	2.5	2.5	2.5	2.5

Notes - 2002

Note: For 2002, LEAD program provided an estimated figure for all children screened, including non-Medicaid, of 6 months to 6 years, of 28,583.

Source of data: Indiana LEAD program. Note: This figure represents a clarification from the LEAD program in terms of the population screened. This is the second year this measure is reported on and should be considered provisional data. This figure may change subsequent to receipt of further information from HMOs with whom Medicaid contracts.

Notes - 2003

In 2004 actual figures from the Lead program are available for the firs t time in terms of number of tests and number of positive elevated blood lead levels. Data for 2003 was able to be gleaned from the same computer system. Objectives have been changed to reflect an increase in actual number of children tested.

Source of data: Indiana Childhood Lead Prevention Program (ICLPP).

Notes - 2004

In 2004 actual figures from the Lead program are available for the firs ttime in terms of number of tests and number of positive elevated blood lead levels. Data for 2003 was able to be gleaned from the same computer system. Objectives have been changed to reflect a decrease in actual number of children tested with elevated blood lead levels, beginning with baseline data of 1,095 children from 2004 (percentage of 2.5).

Source of data: Indiana Childhood Lead Prevention Program (ICLPP).

a. Last Year's Accomplishments

FY 2004 Performance Objective: During SFY 2004, 17,500 children aged 6 months through 6 years on Medicaid will be screened.

OBJECTIVE MET at 43,137

*MCSHC staff and Indiana Childhood Lead Poisoning Prevention Program (ICLPPP) staff provided training on lead screening tools, new guidelines etc., to grantees, physicians, health departments, Healthy Families, Head Start and several Health Departments.
*ICLPPP engaged the support of Improving Kids Environment (IKE), an advocacy group, for the purpose of public awareness about the issue. IKE conducted several media blitzes that encouraged primary prevention and screening of children.
* ICLPPP continued to work on achieving compliance with the Children's Health Act of 2000 by implementing the requirements of PL 99,and HB 1171, mandating the reporting of blood lead levels (to begin July 1, 2003) to ISDH and sharing the data between appropriate state and local agencies (retroactive to January 1, 2001).
*ICLPPP and its many partners developed the Indiana Lead Elimination Plan. The plan was submitted to the Centers for Disease Control (CDC) and approved by CDC. Indiana's Lead Elimination Plan is currently used by CDC as a model for other States to follow in the development of their Lead Elimination Plan. The secondary prevention aspect of the plan includes activities that will be implemented in FY 2005 to increase screening of children.
ICLPPP began the process of implementing the Elimination as follows:
*Five MCSHC grant applications were submitted to implement pilots on lead issues. Three were funded and will address different aspects of primary prevention of lead poisoning.
*Six communities actively partnered and nine applications were submitted in June of 2004 to apply for Housing and Urban Development Healthy Homes and Lead Hazard Control Grants.
*ICLPPP is working with "The Lead Safe 2010 Project", a public/private partnership supported by the U.S. Department of Housing and Urban development (HUD) to develop new strategies to finance the elimination of lead paint poisoning in the United States. The goal is to leverage federal, state, local and other fiscal resources with new funding from foundations, banks, and corporations.
*ICLPPP staff has met with Indiana Housing Finance Authority (IHFA) staff to promote methods for including lead hazard control in the CDBG application process.
*Established a group of experts that have met and began to look at other systems available and how those systems can be linked to a housing centralized database.
*ICLPPP staff met with Foster Care, Child Care, Healthy Families, Head Start, Medicaid, and Housing and Community Services to begin the process of sharing data for tracking of families and homes.
*ICLPPP is working with the Children and Hoosiers Immunization Registry Program (CHIRP) and Regenstrief to link lead data with CHIRP.
See Attachment

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

	Pyramid Level of

Activities	Service			
	DHC	ES	PBS	IB
1. ICLPPP will continue the CDC grant for elimination of childhood elevated lead levels.				X
2. ICLPPP will partner with MCOs, OMPP, HDs, & local coalitions & other private/public funding sources.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: During SFY 2005, 20,000 children aged 6 months through 6 years on Medicaid will be screened.

*4,163 Medicaid children have been tested for lead from 10/1/2004 to 3/31/2005
* ICLPPP provided training in February of 2005 to 10 communities, 25 agencies, and 65 individuals on applying for HUD's Lead Hazard Control grants. Jane Malone from the Alliance for Healthy Homes, Dr. Sami Khawaja president of an evaluation firm, provided training on the grants and on the logic model.
*Funds obtained for campaign to determine awareness of parents of at-risk children, property owners, real estate agents, contractors and home re-modelers of known lead hazards.
*Implement awareness campaign for State policy makers, and elected officials to measure awareness of lead hazard awareness.
*ICLPPP is working with the Foundation Project to address increasing resources through foundations for financing an awareness campaign that will increase lead awareness for parents, real estate owners, contractors and the general population. A presentation will be made in May 2005.
*Determine number of providers currently testing and following-up on at-risk children who have been routinely testing for lead poisoning. ICLPPP is working with OMPP to complete measures of OMPP providers that are currently testing children for lead based on the HEIDIS measures authorized by the National Committee for Quality Assurance. Baselines will be determined this year. Follow-up testing to determine progress in providers testing will be determined each year.
*ICLPPP developed new screening guidelines for medical providers that addresses the targeting of high risk children and defines confirmatory testing and follow-up of children and sent the new tool to all health departments, and to the screening committee, for feedback. The form Version D was finalized in April of 2005.
*Lead Data is in CHIRP and available for medical providers, local health departments, WIC clinics, MCSHC clinics to view through CHIRP. 45,000 lead records are now available in the CHIRP registry.
*ICLPPP will continue to implement all aspects of the Lead Elimination Plan to continue to increase children tested, awareness in the population, and housing units tested for lead. ICLPPP has implemented many areas of the plan including lead testing of homes.

c. Plan for the Coming Year

*This SP will be modified to become SP 05.

Planned activities for all new State Negotiated Performance Measures are appended to the FY 2006 5-Year Needs Assessment.

State Performance Measure 15: *To facilitate the integration of genetics and build genetics capacity within other areas of public health.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		1	2	3	4
Annual Indicator		1	3	3	4
Numerator		1	3	3	4
Denominator	5	5	5	5	5
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5	5	5	5	5

Notes - 2003

The measure for the facilitation of the genetics integration and capacity building is to achieve at least one of the following five objectes each year over five years. As of 2003, the ISDH genetics program has achieved success in three of the five areas and has begun work on the remaining two. The needs assessment will completed in FY04, and the final report on the feasiblity of integration with various public health systems will be completed no later than FY05.

1. Conduct a needs assessment of gentic services.
2. Develop a state genetics plan.
3. Implement the state genetics plan.
4. Ascertain the feasiblity of integratin various public health information systems to improve the quality of birth defects surveillance.
5. Develop educational materials for genetic conditions and services .

Notes - 2004

The measure for the facilitation of the genetics integration and capacity building is to achieve at least one of the following five objectives each year over five years. As of 2004, the ISDH genetics program has achieved success in three of the five areas and has begun work on the remaining two. The needs assessment will completed in FY04, and the final report on the feasiblity of integration with various public health systems will be completed no later than FY05.

1. Conduct a needs assessment of genetic services.
2. Develop a state genetics plan.
3. Implement the state genetics plan.

4. Ascertain the feasiblity of integrating various public health information systems to improve the quality of birth defects surveillance.
5. Develop educational materials for genetic conditions and services .

a. Last Year's Accomplishments

FY 2004 Performance Objective: MCSHC will complete at least four of five defined measures of integration and capacity building by the end of FY 2004.

OBJECTIVE MET at 4

*The Indiana Genetics Advisory Committee (IGAC) convened semi-annually.
*Educational materials for genetic conditions and services included:
*Two issues of the Genomics Program newsletter, "Transcriptions", were published and sent state-wide to approximately 3,000 health care professionals.
*Ten presentations of statewide talks about birth defect surveillance in Indiana and the benefits of folic acid for the prevention of certain birth defects.
*Birth Certificates, Newborn Screening lab data, and birth defects hospital discharge data were integrated into the ODS and a program was developed to integrate chart audit data and monitor hospital compliance with sending discharge data. The integration of various public information systems to improve the quality of birth defects surveillance continued through participation in the Data Integration Steering Committee (DISC) and integration of data through the Operational Data Store (ODS).
*Implementation of the State Genetics Plan has progressed with the following:
*Developed and implemented a statewide folic acid campaign by the coordinator.
*Continued support of the Indiana Birth Defects and Problems Registry (IBDPR) through staff and contractors providing chart audits to determine the accuracy of data provided by hospital discharge summaries.
*Developed and implemented a system to verify and integrate data from physicians reporting to the IBDPR.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Genomics Prog Director will facilitate meetings of the Indiana Genetics Advisory Committee (IGAC).				X
2. Expand the data integration system to include immunization, IBDPR, vital statistics, etc.				X
3. Develop a method to disseminate resource information to families in the IBDPR registry that is timely.				X
4. Develop and implement a statewide medical genetics educational campaign for prof & lay public.			X	
5. Continue providing the genetics newsletter, "Transcriptions".			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2005 Performance Objective: MCSHCS will complete at least five of five defined measures

of integration and capacity building by the end of FY 2005.

*Continue the facilitation of the Indiana Genetics Advisory Committee (IGAC) through semi-annual meetings.
*Continue development of educational materials for genetic conditions and services through presentations and the newsletter "Transcriptions."
*Implementation of the State Genetics Plan will progress with the following:
*Hire another Genetics Specialist to assist with activities of the grant.
*Development of educational packets for families of children identified with a confirmed birth defect through the Indiana Birth Defects and Problems Registry (IBDPR).
*Implement a method to determine the timeliness of hospital reporting to the IBDPR.
*The integration of various public information systems to improve the quality of birth defects surveillance will continue through the DISC and development of the Operational Data Store (ODS).
*A working data mart for the IBDPR is near completion.
*A Chart Audit Stand Alone (CASA) program was developed for the chart auditors to use on a laptop to minimize data entry.

c. Plan for the Coming Year

This SP will be discontinued and not replaced.

E. OTHER PROGRAM ACTIVITIES

The Indiana Family Helpline (IFHL) is designed to assist in promoting Maternal and Child Health Services, WIC and other programs and services throughout the state. In August 1992, the CSHCS Helpline merged with the IFHL to improve services to all Indiana families. During FY 2004, the IFHL responded to 18,828 calls and made 1,781 advocacy calls, resulting in 58,765 referrals.

The Office of Cultural Diversity and Enrichment was created in March 2001 to help address the public health needs of minorities in Indiana. It was recognized that there was a need to place a stronger emphasis on cultural competency for health care professionals throughout the state, as well as all health care professional employees in the ISDH. On a yearly basis, the Office has conducted the Minority Health Disparity survey. The fifth annual assessment of cultural competence for ISDH contractors described in this plan was designed to continue efforts to improve the ability of contractors to meet the needs of Indiana minority populations in an effective, culturally competent manner. The assessment serves as the basis for requiring contractors to receive training on cultural competence until they demonstrate acceptable levels of performance. If current ISDH contractors demonstrate a continued inability to meet ISDH goals regarding effective, efficient, culturally competent programs, ISDH will seek alternate culturally competent contractors. In order to address the public health needs of Indiana minority groups, the Office of Cultural Diversity and Enrichment began offering a two-day Cultural Competence Workshop twice a month and a one-day Advanced Cultural Competency Workshop that is also held twice a month. To date, 1,300 health care professionals have attended these workshops. The two-day workshops emphasize cultural knowledge and cultural differences, strategies for working with racial/ethnic populations, the principles of interpreter services, and discussion of four different cultures. (African American, Hispanic/Latino, Asian, Native American). The Advanced Workshops focus on dissimilarities in areas such as values, communication patterns, religion, beliefs, and health care professionals limited knowledge of other cultural groups.

The Indiana Child Care Health Consultant Program was established in FY 2003 with the Family Social Services Administration - Bureau of Child Development providing dollars from the Child Care Development Fund, Quality Initiatives Fund, to the State Department of Health to fund the project. The goal of the program is to increase the level of health and safety in out-of-home child care settings across Indiana through technical assistance and training for child care providers. The project provides

another portal to services to increase the level of health and wellness that child care providers, the children they serve and their families, need. Program staff includes a contracted Project Director, six regional child care health consultants, and a part-time support person. The regional child care health consultants are located in the field and coordinate with the numerous individuals and agencies currently involved with child care providers. There are four programmatic functions of the program. They include:
- Identification of licensed, registered, and license-exempt child care settings;
- Collection of data such as the child care settings' programs, health and safety practices, the immunization status and health insurance coverage status of the enrollees, back-to-sleep practices, accident occurrences, and the smoke-free status of the setting;
- Creation or identification and distribution of appropriate health and safety educational materials for use by child care providers and parents;
- Provision of consultation for child care providers around health and safety issues in out-of-home child care settings.
Another major component of the program is data collection and report generation. Documentation of the activities of the regional child care health consultants and the resulting changes in health and safety practices in out-of-home child care settings, and the change in health status of the children enrolled in the programs are two of the major foci. This program is currently being re-designed.

In July 2003, the ISDH/MCSHCS received a two-year grant from MCHB to fund the Indiana Early Childhood Comprehensive Systems (ECCS) Program. The program will create an integrated, coordinated, comprehensive system of services for children from birth to five. The coordinated system will support ease of access to needed services, increase the utilization of appropriate services and support the role of the family as their child's first teacher. This initiative will help to ensure that a holistic system of care supports young children and they arrive at school healthy and ready to learn. A Core Partner (steering committee) group was created which met to establish the Vision, Mission and Values of the program that provided the focus for the planning process The ECCS program staff with ISDH technical staff assistance established a website to promote public participation and facilitate communication across all committees. The site can be found at http://www.in.gov/isdh/programs/mch/eccs/eccsindex.htm. The ECCS Project Director is working closely with other groups promoting healthy children and families that have been initiated by the Governor, Lt. Governor and federal grant opportunities to ensure the work is not being duplicated and that all the groups are communicating and moving forward together. The Implementation phase of the ECCS is scheduled to begin as the statewide strategic plan has been completed and submitted in May 2005 to the Maternal and Child Health Bureau.

F. TECHNICAL ASSISTANCE

Title V 2005 Technical Assistance Request

Description of Technical Assistance Requested
Workshops are needed to address issues surrounding the fact that in Indiana the number of meth labs (Methamphetamine) found statewide has risen from 43 in 1998 to 1549 in 2004, with 15,994 meth labs found producing the drug nationally in 2004.
Reasons Why Assistance Needed
The greatest concentration of Meth Labs has been in the Midwest, and from 2003 to 2004, Indiana moved up the list of labs busted nationwide from sixth place to fourth place. As a result, children of families involved in Methamphetamine use and production in Indiana are disproportionately suffering from various forms of abuse and neglect.
What state, organization or Individual would you suggest providing the TA

Not known at this time

Description of Technical Assistance Requested

Domestic Violence is the leading cause of serious injury to women, more than rape, mugging and car crashes combined. Domestic Violence includes but is not limited to Physical, Sexual, Emotional, and Financial abuse.
Reasons Why Assistance Needed
The number one killer of pregnant women nationally is homicide. Technical assistance for MCH funded and Non-funded projects is desperately needed.

What state, organization or Individual would you suggest providing the TA

Indiana Coalition Against Domestic Violence

V. BUDGET NARRATIVE

A. EXPENDITURES

Annual Budget Expenditure Narrative
FY'04 Budget Expenditures

Indiana's FY 2003 cost-cutting measures included early retirement incentives, a personnel furlough program, and a statewide hire freeze. These programs were implemented for all state personnel positions, whether funded by state funds or other (Federal) funds. While these measures were not continued in FY 2004, the long-term impact still resulted in significant expenditure reductions for both state and Federal funds, as reflected on Form 3, Form 4, and Form 5.

As a result, ISDH MCSHC has increased funding allocations to local projects. Additionally, MCSHC implemented a one-time program to fund infrastructure building and pilot projects at the local level. These projects may be funded for up to three years.

Maintenance of State Effort
In FY'89, Indiana's MCH Block Grant award was $10,527,556 and the State expended $11,539,520 in support of MCH activities. In FY'04 the MCH Block Grant award was $12,746,245 and the State expended $19,245,364 in support. In FY 2006 the MCH award is expected to be $12,265,926 and the State has budgeted $38,999,065. State support includes money provided by state and local funds that MCSHC is authorized to spend on behalf of children with special health care needs. In FY 2004, MCHSC began counting the 30% match required of local projects as part of the Maintenance of State Effort. Line item expenditures for FY'89, FY'04 and budgeted amounts for FY'06 are listed below:

State Funds
Expenditures in 1989
Expenditures in 2004
Budget for 2004

MCH Supplement
$193,223 expended in 1989
$176,700 expended in 2004
$0 budgeted for 2006
(This amount has been reserved to defray a 7% cut in other State funds to the agency. This portion of the State Maintenance of Effort has been effectively replaced and surpassed by other new State program allocations listed below with $0 in allocations and expenditures for 1989.)

Newborn Screening
$33,669 expended in 1989
$828,275 expended in 2004
$1,224,126 budgeted for 2006
(This program is funded by a provider fee for each newborn screened. This fee was increased from $7.50 to $30.00 in 2004.)

Children with Special Health Care Needs
$11,312,628 expended in 1989
$10,734,256 expended in 2004
$29,490,974 budgeted for 2006
(ISDH has seen an increase in projected revenue for State Childrens Special Health Services funds. These are partially funded by county revenue that increased as a result of an increase in assessed property values. The budgeted amount includes carryover funds and reflects the balance in the dedicated account. These funds are dedicated to the CSHCS program to pay for covered health care for CSHCN.)

TDAB Meconium Screening

$0 expended in 1989
$71,213 expended in 2004
$62,496 budgeted for 2006

RESPECT (State sexual abstinence education)
$0 expended in 1989
$459,938 expended in 2004
$596,280 budgeted for 2006

TPSUPP (Prenatal Substance Use Prevention - State Tobacco Settlement Funds)
$0 expended in 1989
$258,900 expended in 2004
$185,231 budgeted for 2006

Local MCH Appropriations
$0 expended in 1989
$674,567 expended in 2004
$1,137,374 budgeted for 2006

Other Matching Funds
$0 expended in 1989
$3,050,850 expended in 2004
$3,353,257 budgeted for 2006

Program Income
$0 expended in 1989
$2,990,665 expended in 2004
$2,949,327 budgeted for 2006

TOTAL
$11,539,520 expended in 1989
$19,245,364 expended in 2004
$38,999,065 budgeted for 2006

FY'04 Unobligated Funds
Lower than projected expenditures in FY 2003 caused the amount of unobligated balance carried over to FY 2004 to increase by more than 10% over this amount for FY 2003.

In FY 2004, ISDH allowed ongoing MCH projects to apply for a 10% increase in requested funds to take into account previous flat-line allocations. Further, ISDH has implemented a one-time, short-term grant program to build infrastructure throughout the state. This will significantly reduce carryover amounts for FY 2005 through FY 2007. Additionally, Title V funds are now called upon to support allowable programs previously supported by funds such as the Preventive Health and Health Services Block Grant that are no longer available. Indiana operates its program on a first in first out basis; therefore the unobligated carryover will be expended first.

B. BUDGET

Annual Budget and Budget Justification

FY'06 Summary Budget

Component A: Services for Pregnant Women, Mothers, and Infants up to age one.
Component B: Preventive and Primary Care Services for Child and Adolescents.
Component C: Family-Centered, Community-Based, Coordinated Care and the development of Community-Based Systems of Care for Children with Special Health Care Needs and their Families.

Administrative Costs: Indirect Costs

Dollars | Percentages

Component A $ 4,166,340 | 33.96%
Component B $ 3,916,938 | 31.93%
Component C $ 3,681,625 | 30.02%
Administrative Cost $ 501,023 | 4.09%
Grant Total $ 12,265,926 | 100.00%

I. Direct Medical Care Services
The $19,530,717 budgeted at this level include all community grants that provide direct services and projected medical claims for CSHCN and hemophilia premiums.

II. Enabling Services
The $24,050,864 budgeted at this level include all community grants that provide enabling services and all other CSHCS state funds not projected for direct medical care services.

III. Population Based Services
The $3,935,733 budgeted at this level include all community grants that will provide population based services, Newborn Screening funds, and Indiana RESPECT funds.

IV. Infrastructure Building Services
The $8,433,775 budgeted at this level include salaries of all staff and other operating expenses (minus insurance premiums and community grant funds), the statewide needs assessment, data systems, and the Indiana Perinatal Network.

Total FY 2006 budget is $55,961,089.

3.3.1 Completion of Budget Forms
See forms 3, 4, and 5.

3.3.2 Other Requirements
Maintenance of State Effort -- See comparisons of FY 1989 and FY 2004 expenditures and FY 2006 budget in previous section.

FY'06 Unobligated Funds
The projected unobligated balance for FY 2006 is $4,696,098, which reflects a decrease from the unobligated balance for FY 2005. Indiana will always indicate funds in this category due to the length of time required to hire staff and the less than 100% payout on approximately sixty contracts per year. These costs are included in full in the projected budget each year. The unobilgated balance will be used for program costs and to fund special projects that address Indiana priorities.

Carryover balances have grown from FY 2001 through FY 2005 as a result of tightened state spending during FY 2002 through FY 2004. ISDH MCSHC has taken a number of steps to use these savings to build infrastructure throughout the state. Ongoing MCH project allocations were increased by nearly a million dollars from FY 2003 to FY 2004 (this increase remains in place) and an additional one-time, short-term grant program has been developed that has obligated an additional $1,034,858 in FY 2005 and will grant out up to an additional million dollars each year during FY 2006 and 2007. These short-term, one-time grants are primarily targeted to conducting Fetal Infant Mortality Reviews, community-based needs assessment and other infrastructure building projects.

MCSHC projects that Title V funds will also be called upon to, where allowable, provide additional support for projects previously funded by funds no longer available such as the Preventive Health and Health Services Block Grant.

Indirect Cost Rate Agreement
The rates listed below and approved in the Rate Agreement between ISDH and DHHS are for use on grants, contracts, and other agreements with the Federal Government subject to the conditions in Section III. It should be noted that Indiana considers indirect costs to be the administrative costs of the programs.

SECTION I: INDIRECT COSTS RATES*
RATETYPES FIXED FINAL PROV.(PROVISIONAL)

PRED.(PREDETERMINED)EFFECTIVEPERIOD
TYPES FROM TO RATES(%) LOCATIONS APPLICABLE
FIXED 07/01/04 06/30/05 7.0 All All Programs
PROV 07/01/05 until amended 7.6 All All Programs

*Based:
Total direct costs excluding capital expenditures (building, individual items of equipment, alterations and renovations), sub-awards and flow-through funds.
7.6% is the maximum rate currently projected for FY'06.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting Documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.